

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 5/55

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8859

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08849

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. at the Memorial Hospital</b>		d. STREET ADDRESS <b>302 Crawford St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Dora</b> Middle <b>Phyllis</b> Last <b>Allen</b>		4. DATE OF DEATH Month <b>Sept</b> Day <b>26</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 21-1892</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Massey</b>		14. MOTHER'S MAIDEN NAME <b>Annie Hall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-30-0690</b>	
17. INFORMANT <b>(daughter) Virginia Williams, Md.</b>		Address <b>Cumberland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> DUE TO <b>Chronic myo carditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis.</b> DUE TO <b>?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>422.1</b> <b>sudden</b> <b>3.1/2 yrs.</b> <b>?</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>H. V. Deming M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>H. V. Deming M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Sept. 27-1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 27, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Summer Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Cumbe. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc. Cumbe. Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DATE Sept. 28, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>M. R. Thattz, M.D.</b>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Within corporate limits: 8860					CERTIFICATE OF DEATH				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					c. LENGTH OF STAY IN 1b <b>15 HRS. 35 MIN</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>					d. STREET ADDRESS <b>FREDERICK ST.</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)			First <b>ALBERT</b> Middle <b>H</b> Last <b>BANKS</b>		4. DATE OF DEATH		Month <b>SEPTEMBER</b> Day <b>25</b> Year <b>19 56</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 13, 1892</b>		9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>EWING Ret. Blrmkr B. &amp; O Railroad</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>EWING BANKS</b>					14. MOTHER'S MAIDEN NAME <b>MARGARET SHULER</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>705-10-6711</b>		17. INFORMANT <b>Benj. Banneker Homes</b> <b>Cumberland, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>157X</b> <b>Coronary of Arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>9</b> p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Sept 25</b> , 19 <b>55</b> , to <b>Sept 25</b> , 19 <b>56</b> , that I lost saw the deceased alive on <b>Sept 25</b> , 19 <b>56</b> , and that death occurred at <b>9:40 AM</b> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>B. M. Schindler</b> M.D.			ADDRESS (Street, city or town, state) <b>41 Brunell, Cumberland Md</b> DATE SIGNED <b>Sept 28, 1956</b>						
PHYSICIAN'S NAME (Type) <b>B. M. Schindler</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 28, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR <b>Sept. 28, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Huntz, M.D.</b>			

CERTIFICATE OF DEATH

1956

NAME OF DECEASED		AGE		SEX		RACE		MARRIED		OCCUPATION	
JAMES E. BULLER		62		M		W		YES		RETIRED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED	
OCT 1 1956		BALTIMORE, MD		HEART DISEASE		NATURAL		YES		JAMES E. BULLER	
DATE OF BIRTH		PLACE OF BIRTH		CAUSE OF BIRTH		MANNER OF BIRTH		CERTIFICATE OF BIRTH		SIGNATURE OF BIRTH	
JAN 1 1900		BALTIMORE, MD		HEART DISEASE		NATURAL		YES		JAMES E. BULLER	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED	
OCT 1 1956		BALTIMORE, MD		HEART DISEASE		NATURAL		YES		JAMES E. BULLER	

BUREAU V. S.

OCT 1 1956

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08851

Within corporate limits

8861

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Allegany</u>	
CITY OR TOWN <u>Cumberland</u>		LENGTH OF STAY (In this place) <u>92 yrs</u>		CITY OR TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>617 N. Carter St</u>				STREET ADDRESS (If rural give location) <u>617 N. Carter St</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Anna</u> (Middle) <u>Emilia</u> (Last) <u>Beale</u>				(Month) <u>Sept</u> (Day) <u>26</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb 3-1864</u>	9. AGE last birthday <u>92</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Adam Schofer</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Tauber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Carrie Gabler - 617 N. Carter St</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
450.0 IMMEDIATE CAUSE (A) <u>Generalized arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Several yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1956</u> , to <u>Sept 26, 1956</u> , that I last saw the deceased alive on <u>Sept 11, 1956</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>H. C. Dunning M.D.</u>				ADDRESS (Street, city, town, state) <u>Sept. 26-1956</u>			
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Sept. 28-1956</u>		NAME OF CEMETERY OR CREMATORY <u>ST. LUKES CEMETERY</u>		LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
24. REC'D BY REGISTRAR <u>Sept. 27, 1956</u>		REGISTRAR'S SIGNATURE <u>W. R. Mantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Steinman</u> ADDRESS <u>Cumberland Md.</u>			

# CERTIFICATE OF DEATH

1. NAME OF DECEASED (Print or Write)

2. SEX (Male or Female)

3. AGE (Years, Months, Days)

4. DATE OF DEATH

5. PLACE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF NEXT OF KIN

14. SIGNATURE OF BURIAL SOCIETY

15. SIGNATURE OF CHURCH

16. SIGNATURE OF OTHER

17. SIGNATURE OF

18. SIGNATURE OF

19. SIGNATURE OF

20. SIGNATURE OF

BUREAU V. 3

SEP 28 1956

RECEIVED

EXHIBITION

8862

CERTIFICATE OF DEATH

08852 4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>8 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b> <b>MEMORIAL &amp; WARWICK AVES.</b>				d. STREET ADDRESS <b>11X-2</b>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>H.</b> Last <b>BECKMAN</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>6</b> Year <b>1956</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 25, 1872</b> <b>SEP 10, 1872</b>	9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer, Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>THEODORE BECKMAN</b>				14. MOTHER'S MAIDEN NAME <b>LOUISE O'BRIEN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>550.1</b> IMMEDIATE CAUSE (a) <b>Peritonitis Generalized Arduous</b> DUE TO <b>Ruptured Appendix</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>24 Aug</b> , 19 <b>56</b> , to <b>6 Sept</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>6 Sept</b> , 19 <b>56</b> , and that death occurred at <b>10:00P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. F. B. Whitworth</b> M.D.				ADDRESS (Street, city or town, state) <b>1231 Bedford St</b>		DATE SIGNED <b>7/29/56</b>	
PHYSICIAN'S NAME (Type) <b>DR. F. B. WHITWORTH</b>				<b>Cummins</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-9-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>North Glade Garrett Co, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Oliver F. Sharpless</b>				ADDRESS <b>Blaine, W. V.</b>		24a. REC'D BY REGISTRAR <b>Sept 9, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. R. Frantz, M.D.</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH-DEATH REGISTRY

1955

FILE NO.

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF DEATH [REDACTED]		5. TIME OF DEATH [REDACTED]		6. PLACE OF DEATH [REDACTED]	
7. CAUSE OF DEATH [REDACTED]		8. MANNER OF DEATH [REDACTED]		9. PLACE OF BIRTH [REDACTED]	
10. OCCUPATION [REDACTED]		11. MARITAL STATUS [REDACTED]		12. EDUCATION [REDACTED]	
13. PREVIOUS ILLNESS [REDACTED]		14. PREVIOUS SURGERY [REDACTED]		15. PREVIOUS TRAUMA [REDACTED]	
16. PREVIOUS DRUGS [REDACTED]		17. PREVIOUS ALCOHOL [REDACTED]		18. PREVIOUS TOBACCO [REDACTED]	
19. PREVIOUS RADIATION [REDACTED]		20. PREVIOUS CHEMOTHERAPY [REDACTED]		21. PREVIOUS TRANSFUSION [REDACTED]	
22. PREVIOUS ORGANS [REDACTED]		23. PREVIOUS TISSUES [REDACTED]		24. PREVIOUS CELLS [REDACTED]	
25. PREVIOUS BLOOD [REDACTED]		26. PREVIOUS SPERM [REDACTED]		27. PREVIOUS OVUM [REDACTED]	
28. PREVIOUS EMBRYO [REDACTED]		29. PREVIOUS FETUS [REDACTED]		30. PREVIOUS INFANT [REDACTED]	
31. PREVIOUS CHILD [REDACTED]		32. PREVIOUS ADULT [REDACTED]		33. PREVIOUS ELDERLY [REDACTED]	
34. PREVIOUS DECEASED [REDACTED]		35. PREVIOUS BURIED [REDACTED]		36. PREVIOUS CREMATED [REDACTED]	
37. PREVIOUS INTERMENT [REDACTED]		38. PREVIOUS MONUMENT [REDACTED]		39. PREVIOUS GRAVE [REDACTED]	
40. PREVIOUS CEMETERY [REDACTED]		41. PREVIOUS CHURCH [REDACTED]		42. PREVIOUS SYNAGOGUE [REDACTED]	
43. PREVIOUS MOSQUE [REDACTED]		44. PREVIOUS TEMPLE [REDACTED]		45. PREVIOUS OTHER [REDACTED]	
46. PREVIOUS OTHER [REDACTED]		47. PREVIOUS OTHER [REDACTED]		48. PREVIOUS OTHER [REDACTED]	
49. PREVIOUS OTHER [REDACTED]		50. PREVIOUS OTHER [REDACTED]		51. PREVIOUS OTHER [REDACTED]	
52. PREVIOUS OTHER [REDACTED]		53. PREVIOUS OTHER [REDACTED]		54. PREVIOUS OTHER [REDACTED]	
55. PREVIOUS OTHER [REDACTED]		56. PREVIOUS OTHER [REDACTED]		57. PREVIOUS OTHER [REDACTED]	
58. PREVIOUS OTHER [REDACTED]		59. PREVIOUS OTHER [REDACTED]		60. PREVIOUS OTHER [REDACTED]	
61. PREVIOUS OTHER [REDACTED]		62. PREVIOUS OTHER [REDACTED]		63. PREVIOUS OTHER [REDACTED]	
64. PREVIOUS OTHER [REDACTED]		65. PREVIOUS OTHER [REDACTED]		66. PREVIOUS OTHER [REDACTED]	
67. PREVIOUS OTHER [REDACTED]		68. PREVIOUS OTHER [REDACTED]		69. PREVIOUS OTHER [REDACTED]	
70. PREVIOUS OTHER [REDACTED]		71. PREVIOUS OTHER [REDACTED]		72. PREVIOUS OTHER [REDACTED]	
73. PREVIOUS OTHER [REDACTED]		74. PREVIOUS OTHER [REDACTED]		75. PREVIOUS OTHER [REDACTED]	
76. PREVIOUS OTHER [REDACTED]		77. PREVIOUS OTHER [REDACTED]		78. PREVIOUS OTHER [REDACTED]	
79. PREVIOUS OTHER [REDACTED]		80. PREVIOUS OTHER [REDACTED]		81. PREVIOUS OTHER [REDACTED]	
82. PREVIOUS OTHER [REDACTED]		83. PREVIOUS OTHER [REDACTED]		84. PREVIOUS OTHER [REDACTED]	
85. PREVIOUS OTHER [REDACTED]		86. PREVIOUS OTHER [REDACTED]		87. PREVIOUS OTHER [REDACTED]	
88. PREVIOUS OTHER [REDACTED]		89. PREVIOUS OTHER [REDACTED]		90. PREVIOUS OTHER [REDACTED]	
91. PREVIOUS OTHER [REDACTED]		92. PREVIOUS OTHER [REDACTED]		93. PREVIOUS OTHER [REDACTED]	
94. PREVIOUS OTHER [REDACTED]		95. PREVIOUS OTHER [REDACTED]		96. PREVIOUS OTHER [REDACTED]	
97. PREVIOUS OTHER [REDACTED]		98. PREVIOUS OTHER [REDACTED]		99. PREVIOUS OTHER [REDACTED]	
100. PREVIOUS OTHER [REDACTED]		101. PREVIOUS OTHER [REDACTED]		102. PREVIOUS OTHER [REDACTED]	

BUREAU V. S.

SEP 13 1955

RECEIVED

8927

CERTIFICATE OF DEATH

08853

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> <u>6</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u> <u>43</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>244 Main</u>		d. STREET ADDRESS <u>244 Main</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Delphia</u> First <u>Burns</u> Middle <u>Biddle</u> Last		4. DATE OF DEATH <u>Sept</u> Month <u>24</u> Day <u>19</u> Year <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1884</u> <u>22 Feb. 1956</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Dayton</u>		14. MOTHER'S MAIDEN NAME <u>Thomzine Pierce</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Louis Biddle</u> Address <u>Westernport, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocarditis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u> DUE TO (c) <u>hypertensive arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr.</u> <u>8 yrs -</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/1</u> , 19 <u>46</u> to <u>9/24/56</u> , that I last saw the deceased alive on <u>9/24/56</u> , 19 <u>56</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>P.E. Berry</u> M.D.		ADDRESS (Street, city or town, state) <u>Piedmont W. Va</u> DATE SIGNED <u>9/25/56</u>	
PHYSICIAN'S NAME (Type) <u>P.E. BERRY</u>		<u>Piedmont W. Va</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/26/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Philos Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Westernport, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Boal</u> ADDRESS <u>Westernport, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 9-25-56</u>	24b. REGISTRAR'S SIGNATURE <u>Joan C Kelly</u>





8863

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY in 1b <b>7 HRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b> <b>MEMORIAL &amp; WARWICK AVES.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>W</b> Last <b>BOCH</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>18</b> Year <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 8, 1909</b>
9. AGE (In years last birthday) yrs. <b>47</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Private Garbage Hauling - Self-employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>A.S.A.</b>	
13. FATHER'S NAME <b>FRANK BOCH</b>		14. MOTHER'S MAIDEN NAME <b>MARY O'BAKER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-07-4770</b>	
17. INFORMANT <b>Memorial Hosp. Records. Cumb Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Spontaneous Pneumothorax with hemorrhage into rt. pleural cavity</b> DUE TO (b) <b>6 hrs</b> DUE TO (c) <b>—</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>— 19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/12/56</b> , 19 <b>56</b> , to <b>9/18/56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9/18/56</b> , 19 <b>56</b> , and that death occurred at <b>7:35 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b>		ADDRESS (Street, city or town, state) <b>Cumberland Md</b>	
PHYSICIAN'S NAME (Type) <b>RICHARD J. WILLIAMS</b>		DATE SIGNED <b>9/18/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Sept 21-1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter &amp; Paul Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc.</b>		ADDRESS <b>Cumberland Md.</b>	
24a. REC'D BY REGISTRAR <b>[Signature]</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

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BUREAU V. 3

SEP 24 1956

RECEIVED

8941

## CERTIFICATE OF DEATH

Reg. Dist. No.

6

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Franklin</u>		c. LENGTH OF STAY IN 1b <u>32 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Franklin Rural 1 Mi N. Westernport</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marian</u> First <u>Bosley</u> Middle Last				4. DATE OF DEATH <u>Sept</u> Month <u>26</u> Day <u>19</u> Year <u>56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>22 Mar. 1878</u>		9. AGE (In years last birthday) <u>78</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>West Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Schell</u>				14. MOTHER'S MAIDEN NAME <u>Mary Cosner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Paul Bosley Westernport, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis and Myocardial Degeneration Not Specified as Rheumatic</u> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 Years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 25</u> , 19 <u>55</u> , to <u>Sept 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 26</u> , 19 <u>56</u> , and that death occurred at <u>6:05 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Piedmont, W. Va.</u> DATE SIGNED <u>Sept 28, 1956</u>							
ACTUAL SIGNATURE <u>Paul R. Wilson</u> M.D. <u>Piedmont, W. Va.</u>				PHYSICIAN'S NAME (Type) <u>Sept 28, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Philos</u>		22d. LOCATION (City, town, or county) (State) <u>Westernport Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E.S. Boal</u> ADDRESS <u>Westernport, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>9-30-56</u>		24b. REGISTRAR'S SIGNATURE <u>John C. Kelly</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. S.

OCT 3 1956

RECEIVED



8864

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>935 Gay St.,</u>				STREET ADDRESS (If rural give location) <u>935 Gay St.,</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>BESSIE</u>		(Middle) <u>ANN</u>		(Last) <u>BOYLAND</u>		(Month) (Day) (Year) <u>Sept. 12, 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 14, 1884</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Addison, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Nelson Miller</u>				14. MOTHER'S MAIDEN NAME <u>Emma Unble</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u>		16. SOCIAL SECURITY NO. <u>214-16-2243</u>		17. INFORMANT & ADDRESS <u>Mr. Raymond E. Boyland 935 Gay St., Cumberland, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <u>Myocardial Failure</u>						<u>1 Da.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>						<u>154R.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Generalized Rheumatoid Arthritis - Juxta</u>						<u>9 mo.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Generalized Arteriosclerosis</u>						<u>154R.</u>	
19a. DATE OF OPERATION <u>no</u>		19b. MAJOR FINDINGS OF OPERATION <u>no</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 12, 1956</u> to <u>Sept 12, 1956</u> , that I last saw the deceased alive on <u>Sept 12, 1956</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>James M. Davis</u>				ADDRESS (Street, city, town, state) <u>140 Bedford St Cumberland, Md</u> DATE SIGNED <u>9-13-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9/15/56</u>		NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>Sept. 14, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u> ADDRESS <u>Cumberland, Md.</u>			

1 With corporate limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Date of Death _____	Time of Death _____	Place of Death _____	Name of Deceased _____
Age _____	Sex _____	Race _____	Birth Date _____
Cause of Death _____			
Signature of Physician _____			
Signature of Registrar _____			

**BUREAU Y. B.**

SEP 18 1956

**RECEIVED**

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8928 CERTIFICATE OF DEATH

088579  
Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> c. LENGTH OF STAY IN 1b <u>Lifetime</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> d. STREET ADDRESS <u>266 East Main, Frostburg</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>JAMES</u> Middle <u>H.</u> Last <u>BRADY</u>				<b>4. DATE OF DEATH</b> Month <u>9</u> Day <u>13</u> Year <u>1956</u>							
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7/13/1875</u>		<b>9. AGE</b> (In years last birthday) <u>81</u> yrs.		<b>IF UNDER 1 YEAR</b> Months _____ Days _____ Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Helper</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Perry Point Veteran Hospital</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Eckhart Mines</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Patrick Brady</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Honora Kenny</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>214-01-6694</u>		<b>17. INFORMANT</b> <u>266 E. Main</u> <u>Miss Catherine Brady, Frostburg, Md.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>8 hrs</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. _____ p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> _____ (County) _____ (State) _____			
<b>21. I certify that I attended the deceased from</b> <u>Sept 12, 1956</u> , to <u>Sept 13, 1956</u> , that I last saw the deceased alive on <u>Sept 12, 1956</u> , and that death occurred at <u>5:45 PM</u> from the causes and on the date stated above. <b>ACTUAL SIGNATURE</b> <u>WOMC Lane</u> M.D. <u>167 E Main</u> <b>PHYSICIAN'S NAME (Type)</b> <u>WOMC Lane</u> <u>Frostburg Md</u> <u>9-14-56</u>											
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>9/15/56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Michael's Cemetery</u>				<b>22d. LOCATION</b> (City, town, or county) <u>Frostburg</u> (State) <u>Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Hafer Funeral Home</u> <u>23 E. Main, Frostburg</u>						<b>24a. REC'D BY REGISTRAR</b> DATE <u>9-15-56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Wm. Stanley N. Roe</u>			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and cause of death. The text is mostly illegible due to fading and bleed-through.

BUREAU V. 8

SEP 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8865 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08858

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
c. LENGTH OF STAY IN 1b <b>55 yrs.</b>				d. STREET ADDRESS <b>414 Hill St.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. at the Sacred Heart Hospital.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ralph</b> Middle <b>Randolph</b> Last <b>Brant</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>21</b> Year <b>19 56</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 15-1901</b>	
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer- Queen City</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Brewing Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Norman Brant</b>				14. MOTHER'S MAIDEN NAME <b>Violetta <del>Ritzer</del> Pitzer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>214-05-5699</b>			
17. INFORMANT <b>(wife) Haxel Moreland Brant, Cumberland, Md</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>Coronary sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> (c) <b>?</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>H. V. Deming M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>H. V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Sept. 22-1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 24, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. Kight, Cumberland, Maryland.</b>				24a. REC'D BY REGISTRAR <b>Sept. 22, 1956</b>			
				24b. REGISTRAR'S SIGNATURE <b>W. H. Kight, M.D.</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Number and

Number and

Place of death

Residence

Occupation

Place of birth

Marital status

Age

Sex

Color

BUREAU V. 2

SEP 26 1956

RECEIVED

8929

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>			
c. LENGTH OF STAY IN b. <b>3 days</b>				d. STREET ADDRESS <b>Route 2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ISABELLE</b> Middle <b>(KNOX)</b> Last <b>BROADWATER</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>25</b> Year <b>19 56</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-12-1884</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Simon Knox</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Cecil Broadwater, Rt. 2, Frostburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>590x Acute Nephritis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>260x Diabetes</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x Diabetes</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>Sept 21, 1956</b> , to <b>Sept 25, 1956</b> , that I last saw the deceased alive on <b>Sept 24, 1956</b> , and that death occurred at <b>5:00 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wom Lane</b> M.D.				ADDRESS (Street, city or town, state) <b>Frostburg Md.</b>			
PHYSICIAN'S NAME (Type) <b>Wom Lane MD</b>				DATE SIGNED <b>Sept 26 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-27-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Robinson Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Avilton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst,</b>				ADDRESS <b>Frostburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>9-27-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Wm Nancy N. Rose</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or funeral home. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		WIDOWED		DIVORCED		REMARKS			
JAMES EARL RAY		35		M		W		1921		MEMPHIS, TENN.		APRIL 4, 1968		MEMPHIS, TENN.		SHOOTING		HOMICIDE		CIVILIAN		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED			
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S RELIGION		MOTHER'S RELIGION	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

OCT 1 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8866 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08860

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>20 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. at Memorial Hospital</b>				d. STREET ADDRESS <b>604 Kent Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Conrad E Brookley</b>				4. DATE OF DEATH Month Day Year <b>Sept. 19 19 56</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 18-1894</b>		9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Draftsman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>		11. BIRTHPLACE (State or foreign country) <b>Portage, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Conrad Brookley</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Schwab</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>214-07-1674</b>		17. INFORMANT Address <b>(son) Charles A. Brookley, Cumberland, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> about <b>1.1/2 hrs.</b> <b>420.1</b> DUE TO <b>Coronary sclerosis</b> <b>1 yr.</b> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>H. V. Deming M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Sept. 19-1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 21, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland.</b>				24. REC'D BY REGISTRAR <b>Sept. 20, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Frantz, M.D.</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director and Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BARNSTABLE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
John Doe		45 yrs		Male		Caucasian	
Date of Death		Place of Death		Cause of Death		Manner of Death	
Nov 15, 1954		Home		Heart Disease		Natural	
Time of Death		Signature of Physician		Signature of Medical Examiner		Signature of Coroner	
10:30 AM		[Signature]		[Signature]		[Signature]	
Address of Deceased		City		State		County	
123 Main St		Barnstable		Mass		Barnstable	
Occupation		Education		Marital Status		Previous Illnesses	
Farmer		High School		Married		Hypertension	
Date of Birth		Date of Admission to Hospital		Date of Discharge from Hospital		Date of Death	
Nov 1, 1909		Nov 10, 1954		Nov 12, 1954		Nov 15, 1954	

**RECEIVED**  
 SEP 24 1956  
 BUREAU V. 2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08861

8867

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>62 Cumberland</u>			c. LENGTH OF STAY IN 1b <u>4 hrs.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>			d. STREET ADDRESS <u>216 Carroll Street</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Alma</u> Middle <u>B.</u> Last <u>Brooke</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>16</u> Year <u>1956</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>1904</u>		9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Romney W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Bartlett</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Singleton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive C.V. Disease</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chloroform</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
INTERVAL BETWEEN ONSET AND DEATH <u>1-2 yrs</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Sept 16, 1956</u> to <u>Sept 16, 1956</u> , that I last saw the deceased alive on <u>Sept 16, 1956</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <u>B. M. Schindler</u> M.D. <u>9/18/56</u>					
PHYSICIAN'S NAME (Type) <u>B.M. Schindler, M.D.</u> <u>Green St., Cumberland, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/19/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Romney Colored Cem</u>	
22d. LOCATION (City, town, or county) <u>Romney, West Virginia</u>		22e. (State) <u>West Virginia</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hafer Funeral Service, Cumberland, Md.</u>					
24. REC'D BY REGISTRAR <u>Sept 19, 1956</u>					
24b. REGISTRAR'S SIGNATURE <u>W.R. Hantz, M.D.</u>					

CERTIFICATE OF DEATH

BUREAU V. A.

SEP 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G202 9-10-56 et

08862

Within corporate limits

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>59 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edith Bruner</u>		4. DATE OF DEATH <u>Sept. 1 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 28, 1875</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Fisher (deceased)</u>		14. MOTHER'S MAIDEN NAME <u>Ella Smith (deceased)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Karl Fisher (brother)</u>		Address <u>Bedford #4, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 420.0 DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> (c) <u>20 YR.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 mo.</u> <u>20 YR.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Advanced Age</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-4-56</u> , 19 <u>56</u> , to <u>9-1-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-1-56</u> , and that death occurred at <u>Home</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. P. Hallinan, M.D.</u>		ADDRESS (Street, city or town, state) <u>140 Bedford St., Cumberland, Maryland.</u>	
PHYSICIAN'S NAME (Type) <u>J. P. HALLINAN, M.D.</u>		DATE SIGNED <u>9-1-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 4, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Centerville, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. R. Knight</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>W. R. Knight, M.D.</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Knight, M.D.</u>	

CERTIFICATE OF DEATH

BUREAU Y. S.

SEP 6 1956

RECEIVED

8942

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Cumberland</b>		c. LENGTH OF STAY IN 1b <b>Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R. D. #1 Cumberland</b>		e. STREET ADDRESS <b>R.D. #1 Cumberland</b>	
3. NAME OF DECEASED (Type or print) <b>Mary Josephine Buchholtz</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>30,</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 16, 1886</b>
9. AGE (In years last birthday) <b>70 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Part Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas Business</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William A. Buchholtz</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth C. Maus</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-32-3286</b>	
17. INFORMANT <b>Mr. Paul Buchholtz</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant Cachexia</b> <b>199.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Growth in pelvis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocarditis &amp; Endocarditis with Mitral</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 mos 1 year</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept 26, 1956</b> , to <b>Sept 30, 1956</b> , that I last saw the deceased alive on <b>Sept 30, 1956</b> , and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F. Alan G. Murray</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>La Vale, Maryland</b> <b>Oct 1-56</b>	
PHYSICIAN'S NAME (Type) <b>F. Alan G. Murray</b>		<b>La Vale, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-2-1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>S.S. Peter &amp; Paul Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>Oct 2, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. M. M.D.</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

OCT 3 1956

BUREAU V. S.

U.S. DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS  
STATE OF NEW YORK  
CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Race: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

8869 **CERTIFICATE OF DEATH**

08864

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <b>Allegany</b>	STATE <b>Maryland</b> COUNTY <b>Allegany</b>		
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Cumberland</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		
TOWN <b>Cumberland</b>	TOWN <b>Cumberland</b>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Allegany County Infirmary</b>	STREET ADDRESS (If rural give location) <b>537 Greenway Avenue</b>		
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>Agnes C. Buskey</b>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>September 7, 1956</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Single</b>	<b>8. DATE OF BIRTH</b> <b>11/1/1909</b>
<b>9. AGE last birthday</b> <b>46 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> (Months) (Days) <b>IF UNDER 24 HRS.</b> (Hours) (Min.)	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if done during leisure hours)</b> <b>Laundry Worker -</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Memorial Hosp. R.</b>	
<b>11. BIRTHPLACE (State or foreign country)</b> <b>Cumberland, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>Joseph Buskey</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Catherine C. McDonald</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b> <b>No</b>		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT &amp; ADDRESS</b> <b>Allegany County Infirmary Records</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>18. MEDICAL CERTIFICATION</b>	
<b>592x IMMEDIATE CAUSE (A)</b> <b>Pulmonary Hypostasis</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>48 hrs.</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b> <b>Chronic Myocarditis</b>		<b>?</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO</b> <b>Chronic Hepatitis</b>		<b>?</b>	
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Arthritis &amp; Depression</b>		<b>?</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	
<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)</b> <b>M. 11/23/53</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>	
<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 11/23/53, 1953, to 9/7/56, 1956, that I last saw the deceased alive on 9/7/56, 1956, and that death occurred at 10:40 A.M. from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> <b>Dr. James E. McLean</b>		<b>DATE SIGNED</b> <b>9/7/56</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>24. REGISTRAR'S SIGNATURE</b> <b>Walter R. Frank, M.D.</b>	
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Charles L. George</b>		<b>26. ADDRESS (Street, city, town, state)</b> <b>49 Greene St., Cumberland, Md.</b>	

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

Name of Deceased Joseph Murray		Sex Male	
Date of Birth April 1900		Place of Birth Maryland	
Usual Residence 327 Broadway Avenue		Cause of Death Alcoholism	
Occupation Carpenter		Manner of Death Natural	
Date of Death September 1, 1956		Place of Death Home	
Physician's Name Dr. J. J. [illegible]		Signature of Physician [illegible]	

Witnessed by J. J. [illegible]

BUREAU V. B.

SEP 13 1956

RECEIVED

DR. HODGES

8870

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>5 MINUTES</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>near CUMBERLAND, Rural</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>			
d. STREET ADDRESS <b>RT. #5, BRADDOCK ROAD</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>PAMELA</b> Middle <b>CLARK</b> Last <b>CLARK</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>13</b> Year <b>19 56</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 18, 1956</b>	
9. AGE (In years last birthday) yrs. <b>3</b> Months <b>25</b> Days <b>25</b>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Hours <b>25</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>JULIAN CLARK</b>			
14. MOTHER'S MAIDEN NAME <b>JACQUELYN SPARGO</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT Address <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>204.1</b> IMMEDIATE CAUSE (a) <b>acute Myeloid Leukemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>acute Myeloid Leukemia</b> DUE TO (c) <b>acute Myeloid Leukemia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>54 8/17/56</b> to <b>9/13/56</b> , that I last saw the deceased alive on <b>9/13/56</b> , and that death occurred at <b>2:10 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. R. Hodges</b>				DATE SIGNED <b>9/13/56</b>			
PHYSICIAN'S NAME (Type) <b>W. R. Hodges</b>				ADDRESS (Street, city or town, state) <b>Cumberland, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/15/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys' Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>				ADDRESS <b>Cumberland, Maryland</b>			
24a. REG'D BY REGISTRAR <b>Sept. 14, 1956</b>				24b. REGISTRAR'S SIGNATURE <b>W. R. Frank, M.D.</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## 2342 • J. Neurosci., September 24, 2008 • 28(39):2337–2347

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CELESTIAL

Case 1:20-cv-00005 Document 1-1 Filed 01/27/21 Page 1 of 1

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005452 WYLLI, DONALD

2002年5月

BUREAU V. S.

SEP 18 1956

RECEIVED



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08866

8943

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Allegany</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>McCoole</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>McCoole</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>70 Howard St.</b>				STREET ADDRESS (If rural give location) <b>70 Howard St.</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Rose</b> (Middle) <b>Ravenscroft</b> (Last) <b>Clark</b>				(Month) <b>Sept.</b> (Day) <b>17</b> (Year) <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Dec. 26, 1880</b>	9. AGE last birthday <b>75</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Dawson, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Ravenscroft</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Dayton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS <b>Mrs. Robert May, McCoole, Md</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <b>Pulmonary embolism</b>				INTERVAL BETWEEN ONSET AND DEATH <b>9-17-56</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Myocarditis</b>				<b>Feb 1955</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <b>Hypertension - myocarditis</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>9-17-56</b> , to <b>9-17-56</b> , that I last saw the deceased alive on <b>9-17-56</b> , and that death occurred at <b>6 AM</b> , from the causes and on the date stated above.							
SIGNATURE <b>W. Chippin</b>		M.D.		ADDRESS (Street, city, town, state) <b>Keyser, W. Va.</b>		DATE SIGNED <b>9-17-56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Sept. 19/56</b>		NAME OF CEMETERY OR CREMATORY <b>Dayton Cemetery</b>		LOCATION (City, town, or county) (State) <b>Dawson, Md.</b>	
24. REC'D BY REGISTRAR <b>Jean C. Kelly</b>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <b>Burnhamwood</b>		ADDRESS <b>Keyser, W. Va.</b>	
DATE <b>9-18-56</b>							

# STATE OF NEW YORK DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

BUREAU V. S.

SEP 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8930

## CERTIFICATE OF DEATH

08867

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>All-gary</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>		c. LENGTH OF STAY IN 1b <u>66 Yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>307 Rock</u>		d. STREET ADDRESS <u>307 Rock</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Russell Henry Coleman</u>		4. DATE OF DEATH Month Day Year <u>Sept 3 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28 Feb. 1863</u>
9. AGE (In years last birthday) yrs. <u>93</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper Finisher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Mill</u>	
11. BIRTHPLACE (State or foreign country) <u>W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Otha Coleman</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Duckworth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Mary E. Coleman-Westernport, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis and Myocardial Degeneration</u> <u>415X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <u>specified as Rheumatic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>60 Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 5, 1956</u> , to <u>Sept 3, 1956</u> , that I last saw the deceased alive on <u>Sept. 2, 1956</u> , and that death occurred at <u>7:40 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul B. Wilson</u>		M.D. <u>Piedmont, W.Va</u>	
DATE SIGNED <u>9-5-56</u>			
18. ACTUAL SIGNATURE <u>Paul B. Wilson</u>		M.D. <u>Piedmont, W.Va</u>	
DATE SIGNED <u>9-5-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 5, 56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Philos</u>		22d. LOCATION (City, town, or county) (State) <u>Westernport Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>El Boal</u>		ADDRESS <u>Westernport, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>9-5-56</u>		24b. REGISTRAR'S SIGNATURE <u>Joan C Kelly</u>	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

BUREAU V. S.

SEP 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08868

8871

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>8/2/56</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>108 Maple Street, Frostburg, Md.</b>		22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		d. STREET ADDRESS <b>108 Maple Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Isabelle</b> Last <b>College</b>		4. DATE OF DEATH Month <b>September</b> Day <b>28</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/12/1875</b>
9. AGE (In years and birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Clearfield, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Wilkins</b>		14. MOTHER'S MAIDEN NAME <b>Jane Reed</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Allegany County Infirmary Records</b>		Address <b>P.O. Box 599, City</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Cerebral Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Nephritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/2/56</b> , 19____, to <b>9/28/56</b> , 19____, that I last saw the deceased alive on <b>9/28/56</b> , 19____, and that death occurred at <b>11:15 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. McLean</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>19 Greene St. Cumberland, Md. 9/28/56</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/1/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park Frostburg</b>		22d. LOCATION (City, town, or county) (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul H. Wintermantel</b>		24a. REC'D BY REGISTRAR <b>Winter R. Mandy, MD.</b>	
24b. REGISTRAR'S SIGNATURE <b>Winter R. Mandy, MD.</b>		DATE <b>Oct 3, 1956</b>	



RECEIVED

BUREAU A. S.

8872

## CERTIFICATE OF DEATH

08869

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Dead On Arrival-Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Norris</u> Last <u>Compton</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8, 1874</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank W. Norris</u>				14. MOTHER'S MAIDEN NAME <u>Anna Hoover</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Miss Lillian Compton, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Regeneration with failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis -</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>9-19-56</u> <u>1945</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>9-19</u> , 19 <u>56</u> to <u>9-19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-19</u> , 19 <u>56</u> , and that death occurred at <u>536 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>H. W. Eliason</u> M.D.							
PHYSICIAN'S NAME (Type) <u>H. W. ELIASON - 126 Union St. Cumberland Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-22-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>Sept 21, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Frank, M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

S. A.

BUREAU V. S.

SEP

RECEIVED  
SEP 24 1966

Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8873

## CERTIFICATE OF DEATH

Reg. Dist. No.

08870

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>13 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>				d. STREET ADDRESS <u>114 Winton Place</u>			
3. NAME OF DECEASED (Type or print) First <u>Homer</u> Middle <u>H</u> Last <u>Cooper</u>				4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 7, 1901</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days		12. IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Brewery</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
13. FATHER'S NAME <u>George W. Cooper</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-03-9022</u>			
17. INFORMANT <u>Mrs. Elizabeth Cooper</u>				Address <u>114 Winton Place, Cumb. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiao-renal failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cor pulmonale</u> DUE TO (c) <u>Emphysema</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>12 mos</u> <u>18 mos</u> <u>5 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12-21</u> , 19 <u>55</u> , to <u>9-13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-13</u> , 19 <u>56</u> , and that death occurred at <u>1:00</u> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>RW Ballin</u> M.D.							
PHYSICIAN'S NAME (Type) <u>R.W. Ballin, M.D.</u> <u>62 Greene St.</u> <u>Cumberland, Md.</u> <u>9-14-56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harman, W. Virginia</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u> <u>Cumberland, Md.</u>				24. REC'D BY REGISTRAR <u>Sept. 15, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>W. R. Frank, M. D.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1956

BUREAU V. 2

SEP 13 1956

RECEIVED



8874

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>627 Elwood Street</u>			
3. NAME OF DECEASED (Type or print) <u>Nancy Ann Coyle</u>				4. DATE OF DEATH Month <u>September</u> Day <u>11</u> Year <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 9, 56</u>		9. AGE (In years last birthday) yrs. <u>2</u> Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.		IF UNDER 24 HRS. Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>James E. Coyle</u>			
14. MOTHER'S MAIDEN NAME <u>Mary M. Kilduff</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT Address <u>Cumberland, Md</u> <u>Patients chart &amp; James E. Coyle 627 Elwood St.,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>770.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congenital Heart Disease</u> (c) <u>Erythroblastosis Fetalis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>10:35 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leland B. Pansom</u> M.D.				ADDRESS (Street, city or town, state) <u>63 Greene St., Cumberland</u> DATE SIGNED <u>11/12/56</u>			
PHYSICIAN'S NAME (Type) <u>L. B. Pansom, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u>				ADDRESS <u>Cumberland, Maryland</u>			
24a. REC'D BY REGISTRAR <u>Sept. 12, 1956</u>				24b. REGISTRAR'S SIGNATURE <u>W. R. Hantz, M.D.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. 8

SEP 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8931 CERTIFICATE OF DEATH

08872  
9

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg, Rural Route # 1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		d. STREET ADDRESS <b>Frostburg, Rural Route # 1</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Cutter</b> Last <b>Cutter</b>		4. DATE OF DEATH Month <b>9/28/1956</b> Day <b>19</b> Year <b>19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/20/1871</b>
9. AGE (In years lost birthday) yrs. <b>85</b>		IF UNDER 1 YEAR: Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min. <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mine</b>	
11. BIRTHPLACE (State or foreign country) <b>Lonaconing, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick Cutter</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Humberson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Clinton Cutter, Frostburg, Md. R.F.D. 1</b>	
17. INFORMANT <b>Clinton Cutter, Frostburg, Md. R.F.D. 1</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Constrictive Heart Failure</b> DUE TO (c) <b>Phlebotomy &amp; Curia</b> INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Months</b> <b>Months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8</b> , 19 <b>56</b> , to <b>9/28</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9/27</b> , 19 <b>56</b> , and that death occurred at <b>2 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>134 E Main Frostburg, Md</b> DATE SIGNED <b>9/28/56</b>			
ACTUAL SIGNATURE <b>John C. Devers</b> M.D.		PHYSICIAN'S NAME (Type) <b>John C. Devers</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/1/1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cutter Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Klondyke, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHORN, Lonaconing, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>10-1-56</b>	
24b. REGISTRAR'S SIGNATURE <b>Mrs. Nancy A. Roe</b>			

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH AND WELFARE

11/1/56

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BUREAU V. 3.

OCT 9 1956

RECEIVED

DR. R.J. WILLIAMS

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>MT. SAVAGE RFD 125</b>	
3. NAME OF DECEASED (Type or print) First <b>DELORES</b> Middle <b>ANN</b> Last <b>DIEHL</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>12</b> Year <b>19 56</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 13, 1935</b>
9. AGE (In years last birthday) <b>20</b> yrs.		IF UNDER 1 YEAR: Months <b>20</b> Days <b>20</b> Hours <b>20</b> Min. <b>20</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BENJAMIN ORT</b>		14. MOTHER'S MAIDEN NAME <b>CORA ROBERTSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-32-4897</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia + Kidney shut down</b> DUE TO <b>260X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Lipemia complicating</b> DUE TO <b>Diabetes Mellitus</b> (c) <b>Diabetes Mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>—</b> 19 p. m. <b>—</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/8/56</b> , 19 <b>56</b> , to <b>9/12/56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9/12/56</b> , 19 <b>56</b> , and that death occurred at <b>10:50 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland Md</b> DATE SIGNED <b>9/12/56</b>			
ACTUAL SIGNATURE <b>DR. R.J. WILLIAMS</b>		PHYSICIAN'S NAME (Type) <b>DR. R.J. WILLIAMS</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 15/1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Meth. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Mt Savage Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Stein Inc. Cumberland Md</b>		ADDRESS <b>Cumt Md</b>	
24b. REC'D BY REGISTRAR <b>Sept. 14, 1956</b>		24c. REGISTRAR'S SIGNATURE <b>DR. Frank D.D.</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. RACE

4. PLACE OF BIRTH

5. DATE OF BIRTH

6. PLACE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. SEX

13. DATE OF DEATH

14. PLACE OF DEATH

15. NAME OF DECEASED

16. SEX

17. RACE

18. PLACE OF BIRTH

19. DATE OF BIRTH

20. PLACE OF DEATH

21. DATE OF DEATH

22. TIME OF DEATH

23. PLACE OF DEATH

24. CAUSE OF DEATH

25. MANNER OF DEATH

26. SEX

27. NAME OF DECEASED

RECEIVED  
SEP 18 1956  
BUREAU V. 2

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

10

8944

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Savage</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Savage</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Old Row</b>				d. STREET ADDRESS <b>R.D. #1, Wellersburg Rd</b>			
3. NAME OF DECEASED (Type or print) First <b>Lulu</b> Middle <b>A.</b> Last <b>Diehl</b>				4. DATE OF DEATH Month <b>9</b> Day <b>15</b> Year <b>1956</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 - 10 - 1889</b>		9. AGE (In years last birthday) <b>67 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Eckhart, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Peter Paul Michaelis</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Martin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Michael E. Flanigan, Mt. Savage, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma to lungs, abdominal organs.</b> 170x DUE TO <b>Carcinoma, right breast.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b> <b>8 years</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>p. m.</b> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 9, 1955</b> , to <b>Sept. 14, 1956</b> , that I last saw the deceased alive on <b>Sept. 14, 1956</b> , and that death occurred at <b>8:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Thomas F. Lewis, M.D.</b>				5 Washington Street			
PHYSICIAN'S NAME (Type) <b>Thomas F. Lewis, M.D.</b>				<b>Cumberland, Allegany County, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-18-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Savage, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B.H. Monticant</b>				ADDRESS <b>Hafer Funeral Home</b>		24a. REC'D BY REGISTRAR <b>9/20/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Veronica M. Dermitt</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 24 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)  
SM 9/55

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08875

8876

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH  
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
Cumberland

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE

W.Va.

b. COUNTY

Mineral

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Ridgely

85 X - 3

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

D.O.A. at the Sacred Heart Hospital

d. STREET ADDRESS

14 Perry St.

e. IS RESIDENCE ON A FARM?  
YES ☐ NO ☒

3. NAME OF DECEASED  
(Type or print)

First

James

Middle

Paul

Last

Dittmer Jr.

4. DATE OF DEATH

Month

Sept.

Day

30

Year

19 56

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☒

8. DATE OF BIRTH

Sept. 22-1924

9. AGE (In years last birthday)

32 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Metal worker

10b. KIND OF BUSINESS OR INDUSTRY

Fairchilds

11. BIRTHPLACE (State or foreign country)

Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Paul Dittmer, Sr.

14. MOTHER'S MAIDEN NAME

Villa Grace

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

Yes-Navy W.W. 2

16. SOCIAL SECURITY NO.

219-14-5171

17. INFORMANT

Address

(father) Jas. P. Dittmer, Ridgely, W. Va.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH  
sudden

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Coronary sclerosis

?

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Hour  
a. m.  
p. m.

Month, Day, Year  
19

20d. INJURY OCCURRED  
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined cause ☐.

ACTUAL SIGNATURE

H. V. Deming M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ASSISTANT MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type)

H. V. Deming M.D.

DEPUTY MEDICAL EXAMINER ☒ Sept. 30-1956

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

10/3/56

22c. NAME OF CEMETERY OR CREMATORY

Hillcrest Burial Pk.

22d. LOCATION (City, town, or county)

Cumberland, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

H. Wayne George, Cumberland, Md.

ADDRESS

24a. REC'D BY REGISTRAR

DATE Oct. 2, 1956

24b. REGISTRAR'S SIGNATURE

H. R. Thant, M.D.

RECEIVED

OCT 3 1956

BUREAU V. 3



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08876

8945

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barton</u>		c. LENGTH OF STAY IN 1b <u>10 Yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Temperance St.</u>		d. STREET ADDRESS <u>Temperance St</u>	
3. NAME OF DECEASED (Type or print) <u>Oliver</u> First <u>Cass</u> Middle <u>Fazenbaker</u> Last		4. DATE OF DEATH <u>Sept</u> Month <u>6</u> Day <u>19</u> Year <u>56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 14, 1880</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Marcus Fazenbaker</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Broadwater</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. O.C. Fazenbaker-Westernport</u> Address <u>Barton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease with congestive heart failure</u> DUE TO (b) <u>failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>53</u> , to <u>Sept 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 6</u> , 19 <u>56</u> , and that death occurred at <u>4:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Piedmont W. Va.</u> DATE SIGNED <u>9-7-56</u> ACTUAL SIGNATURE <u>Jam. M. Johnston Jr.</u> M.D. <u>Piedmont W. Va.</u> PHYSICIAN'S NAME (Type) <u>Jam. M. Johnston Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/8/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Philos Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Westernport Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Boal</u> ADDRESS <u>Westernport, Md.</u>		24a. REC'D BY REGISTRAR <u>9-9-56</u> DATE <u>9-9-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Jeon C Kelly</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES EARL RAY		35		M		W		4/4/68	
PLACE OF DEATH		CITY		COUNTY		STATE		ZIP CODE	
ST. LOUIS, MISSOURI		ST. LOUIS		ST. LOUIS		MISSOURI		63101	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		HEART DISEASE	
DATE OF BIRTH		DATE OF DEATH		DATE OF BURIAL		DATE OF INTERMENT		DATE OF CREMATION	
4/4/33		4/4/68		4/4/68		4/4/68		4/4/68	
PLACE OF BURIAL		CITY		COUNTY		STATE		ZIP CODE	
ST. LOUIS, MISSOURI		ST. LOUIS		ST. LOUIS		MISSOURI		63101	
NAME OF FUNERAL HOME		CITY		COUNTY		STATE		ZIP CODE	
ST. LOUIS, MISSOURI		ST. LOUIS		ST. LOUIS		MISSOURI		63101	
NAME OF PHYSICIAN		CITY		COUNTY		STATE		ZIP CODE	
ST. LOUIS, MISSOURI		ST. LOUIS		ST. LOUIS		MISSOURI		63101	
NAME OF HOSPITAL		CITY		COUNTY		STATE		ZIP CODE	
ST. LOUIS, MISSOURI		ST. LOUIS		ST. LOUIS		MISSOURI		63101	
NAME OF CORONER		CITY		COUNTY		STATE		ZIP CODE	
ST. LOUIS, MISSOURI		ST. LOUIS		ST. LOUIS		MISSOURI		63101	
NAME OF JURY		CITY		COUNTY		STATE		ZIP CODE	
ST. LOUIS, MISSOURI		ST. LOUIS		ST. LOUIS		MISSOURI		63101	
NAME OF JURY		CITY		COUNTY		STATE		ZIP CODE	
ST. LOUIS, MISSOURI		ST. LOUIS		ST. LOUIS		MISSOURI		63101	

*James Earl Ray*  
*Attorney*  
*St. Louis, Missouri*

BUREAU V. 1

SEP 13 1956

RECEIVED

Outside of  
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08877

Reg. Dist. No. 4

1. a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural) Cumberland</b> c. LENGTH OF STAY IN 1b <b>at home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>B&amp;O R.Ry. near North Branch, Md.</b>		d. STREET ADDRESS <b>224 Harrison St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Kenneth</b> Middle <b>Wayne</b> Last <b>Files</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>24</b> Year <b>19 56</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 3-1933</b>
9. AGE (In years last birthday) <b>23</b> yrs.		IF UNDER 1 YEAR Months <b>24</b> Days <b>19</b> Hours <b>56</b> Min.	IF UNDER 24 HRS. Hours <b>56</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pitts. P &amp; G. Co Cumberland, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter F. Files</b>		14. MOTHER'S MAIDEN NAME <b>Ida Shears</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W.2 220-28-7625</b>	
17. INFORMANT <b>(wife) lois Files, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial hemorrhage due to a crushed skull, fractures of all extremities, ribs, right clavicle &amp; pelvis.</b> DUE TO (b) <b>810X</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <b>In auto at B&amp;O R.Ry. North Branch Crossing.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>sudden</b>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto stalled on reverse &amp; hit by a B&amp;O diesel engine.</b>	
20c. TIME OF INJURY Month, Day, Year <b>7-15-56 Sept 24 19 56</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, factory, street, office, drug, etc.) <b>B&amp;O R.Ry Crossing</b>		20f. (City or town) <b>Cumberland, Allegany, Md.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Davis Memorial</b>		22b. DATE THEREOF <b>Sept. 26, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Maryland</b>	
24a. RECD BY REGISTRAR <b>Sept. 26, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>M. R. Mandy M.D.</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

BUREAU OF

SEP 28 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

DR. TOPPER

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYNDMAN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL—MEMORIAL AVE.</b>		d. STREET ADDRESS <b>RT. #1</b>	
3. NAME OF DECEASED (Type or print) First <b>MELVILLE</b> Middle <b>M</b> Last <b>FOST</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>26</b> Year <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 29</b>
9. AGE (In years last birthday) <b>74</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory wkr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese</b>	
11. BIRTHPLACE (State or foreign country) <b>PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY FOST</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET SALYARDS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-10-5338</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL—CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Left Lung</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 months</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1956</b> to <b>Sept 26, 1956</b> , that I last saw the deceased alive on <b>Sept 26, 1956</b> , and that death occurred at <b>1:00 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John A. Topper</b>		ADDRESS (Street, city or town, state) <b>Hyndman Pa.</b>	
PHYSICIAN'S NAME (Type) <b>John A. Topper</b>		DATE SIGNED <b>9-27-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-30-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Palo Alto Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hyndman, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey Zeigler</b>		ADDRESS <b>Hyndman, Pa.</b>	
24a. REC'D BY REGISTRAR <b>DATE Sept 28, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Orant, M.D.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Memorial Hospital - St. Louis, Mo.	
7. DATE OF BIRTH March 10, 1933		8. TIME OF BIRTH 10:00 AM		9. PLACE OF BIRTH St. Louis, Mo.	
10. DATE OF DEATH April 4, 1968		11. TIME OF DEATH 2:01 PM		12. PLACE OF DEATH Memorial Hospital - St. Louis, Mo.	
13. DATE OF BIRTH March 10, 1933		14. TIME OF BIRTH 10:00 AM		15. PLACE OF BIRTH St. Louis, Mo.	
16. DATE OF DEATH April 4, 1968		17. TIME OF DEATH 2:01 PM		18. PLACE OF DEATH Memorial Hospital - St. Louis, Mo.	
19. DATE OF BIRTH March 10, 1933		20. TIME OF BIRTH 10:00 AM		21. PLACE OF BIRTH St. Louis, Mo.	
22. DATE OF DEATH April 4, 1968		23. TIME OF DEATH 2:01 PM		24. PLACE OF DEATH Memorial Hospital - St. Louis, Mo.	
25. DATE OF BIRTH March 10, 1933		26. TIME OF BIRTH 10:00 AM		27. PLACE OF BIRTH St. Louis, Mo.	
28. DATE OF DEATH April 4, 1968		29. TIME OF DEATH 2:01 PM		30. PLACE OF DEATH Memorial Hospital - St. Louis, Mo.	
31. DATE OF BIRTH March 10, 1933		32. TIME OF BIRTH 10:00 AM		33. PLACE OF BIRTH St. Louis, Mo.	
34. DATE OF DEATH April 4, 1968		35. TIME OF DEATH 2:01 PM		36. PLACE OF DEATH Memorial Hospital - St. Louis, Mo.	
37. DATE OF BIRTH March 10, 1933		38. TIME OF BIRTH 10:00 AM		39. PLACE OF BIRTH St. Louis, Mo.	
40. DATE OF DEATH April 4, 1968		41. TIME OF DEATH 2:01 PM		42. PLACE OF DEATH Memorial Hospital - St. Louis, Mo.	
43. DATE OF BIRTH March 10, 1933		44. TIME OF BIRTH 10:00 AM		45. PLACE OF BIRTH St. Louis, Mo.	
46. DATE OF DEATH April 4, 1968		47. TIME OF DEATH 2:01 PM		48. PLACE OF DEATH Memorial Hospital - St. Louis, Mo.	
49. DATE OF BIRTH March 10, 1933		50. TIME OF BIRTH 10:00 AM		51. PLACE OF BIRTH St. Louis, Mo.	
52. DATE OF DEATH April 4, 1968		53. TIME OF DEATH 2:01 PM		54. PLACE OF DEATH Memorial Hospital - St. Louis, Mo.	
55. DATE OF BIRTH March 10, 1933		56. TIME OF BIRTH 10:00 AM		57. PLACE OF BIRTH St. Louis, Mo.	
58. DATE OF DEATH April 4, 1968		59. TIME OF DEATH 2:01 PM		60. PLACE OF DEATH Memorial Hospital - St. Louis, Mo.	
61. DATE OF BIRTH March 10, 1933		62. TIME OF BIRTH 10:00 AM		63. PLACE OF BIRTH St. Louis, Mo.	
64. DATE OF DEATH April 4, 1968		65. TIME OF DEATH 2:01 PM		66. PLACE OF DEATH Memorial Hospital - St. Louis, Mo.	
67. DATE OF BIRTH March 10, 1933		68. TIME OF BIRTH 10:00 AM		69. PLACE OF BIRTH St. Louis, Mo.	
70. DATE OF DEATH April 4, 1968		71. TIME OF DEATH 2:01 PM		72. PLACE OF DEATH Memorial Hospital - St. Louis, Mo.	
73. DATE OF BIRTH March 10, 1933		74. TIME OF BIRTH 10:00 AM		75. PLACE OF BIRTH St. Louis, Mo.	
76. DATE OF DEATH April 4, 1968		77. TIME OF DEATH 2:01 PM		78. PLACE OF DEATH Memorial Hospital - St. Louis, Mo.	
79. DATE OF BIRTH March 10, 1933		80. TIME OF BIRTH 10:00 AM		81. PLACE OF BIRTH St. Louis, Mo.	
82. DATE OF DEATH April 4, 1968		83. TIME OF DEATH 2:01 PM		84. PLACE OF DEATH Memorial Hospital - St. Louis, Mo.	
85. DATE OF BIRTH March 10, 1933		86. TIME OF BIRTH 10:00 AM		87. PLACE OF BIRTH St. Louis, Mo.	
88. DATE OF DEATH April 4, 1968		89. TIME OF DEATH 2:01 PM		90. PLACE OF DEATH Memorial Hospital - St. Louis, Mo.	
91. DATE OF BIRTH March 10, 1933		92. TIME OF BIRTH 10:00 AM		93. PLACE OF BIRTH St. Louis, Mo.	
94. DATE OF DEATH April 4, 1968		95. TIME OF DEATH 2:01 PM		96. PLACE OF DEATH Memorial Hospital - St. Louis, Mo.	
97. DATE OF BIRTH March 10, 1933		98. TIME OF BIRTH 10:00 AM		99. PLACE OF BIRTH St. Louis, Mo.	
100. DATE OF DEATH April 4, 1968		101. TIME OF DEATH 2:01 PM		102. PLACE OF DEATH Memorial Hospital - St. Louis, Mo.	

BUREAU V. S.

OCT 1 1956

RECEIVED

8878

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>HAMPSHIRE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>4 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL, 1800X MEMORIAL &amp; WARWICK AVES</b>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>LEE</b> Last <b>FULLER</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>19</b> Year <b>1956</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPTEMBER 15, 1956</b>		9. AGE (In years last birthday) yrs. <b>3</b> Months <b>3</b> Days <b>29</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>REN FULLER JR.</b>				14. MOTHER'S MAIDEN NAME <b>FAE A. LONG</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Memorial Hospital</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>770.5 DUE TO <i>Erythroblastosis fetalis prematurity</i></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/19</b> , 19 <b>56</b> , to <b>9/19</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9/19</b> , 19 <b>56</b> , and that death occurred at <b>7:55</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. R. Hodges</b>				ADDRESS (Street, city or town, state) <b>Cumersask, Md</b>			
PHYSICIAN'S NAME (Type) <b>W. R. Hodges, M.D.</b>				DATE SIGNED <b>9/21/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Removal</b>		<b>Sept 22, 1956</b>		<b>Ebenazer</b>		<b>Romney</b> <b>W.Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank Shaffer</b>				ADDRESS <b>Romney</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Hodges, M.D.</b>	
24a. REC'D BY REGISTRAR <b>Sept 22, 1956</b>							

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

DATE OF DEATH

05-0

2 DAYS

ALL DAY

05-0

DEATH OF A PERSON WHO WAS A RESIDENT OF THE DISTRICT OF COLUMBIA

WILLI

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FULLER

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DATE OF BIRTH

CHANDLER, WYLAND

1-2-1

FAC A. L. 03

RE: FULLER JR.

Report of Death

BUREAU V. S.

SEP 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8947

## CERTIFICATE OF DEATH

08880

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>			c. LENGTH OF STAY IN 1b <b>84 yrs.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>SARAH JANE GARDNER</b>			4. DATE OF DEATH Month Day Year <b>9/26/1956</b> 19		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb, 22.1872</b>		9. AGE (In years lost birth day) <b>84</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Lonaconing, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William G. Gardner</b>			14. MOTHER'S MAIDEN NAME <b>Eliza Bradley</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT Address <b>Mrs. Robert Matthews, Lonaconing, MD.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Essential Hypertension</b> DUE TO (c) <b>Congestive Heart failure</b>					INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>years</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FORMAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>July 1, 1956</b> to <b>Sept. 26, 1956</b> , that I last saw the deceased alive on <b>Sept. 25, 1956</b> , and that death occurred at <b>4 a. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <b>Leslie R. Miles, Jr.</b> M.D.					
PHYSICIAN'S NAME (Type) <b>Leslie R. Miles, Jr., M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/28/1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lonaconing, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn, Lonaconing, MD.</b>			24a. REC'D BY REGISTRAR DATE <b>10-1-56</b>		24b. REGISTRAR'S SIGNATURE <b>Janette M. Boal</b>

# STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

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BUREAU V. 1

OCT 5 1956

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## 8879 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Allegany</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Cumberland</b>		LENGTH OF STAY (in this place) <b>9/15/56</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Cumberland</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Allegany County Infirmary</b>				STREET ADDRESS (If rural give location) <b>714 St. Mary's Avenue</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Virgil</b>		(Middle) <b>L.</b>		(Last) <b>Gehauf</b>		(Month) (Day) (Year) <b>September 16, 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widower</b>	8. DATE OF BIRTH <b>6/7/1885</b>	9. AGE last birthday <b>71</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - City Employee</b>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Gehauf</b>				14. MOTHER'S MAIDEN NAME <b>Mary Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS <b>Allegany County Infirmary Records</b>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
422.2 IMMEDIATE CAUSE (A)				<b>Pulmonary Emphysema</b>		?	
ANTECEDENT CAUSE(S) DUE TO				<b>Chronic Myocarditis</b>		?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)				<b>Cerebral Arteriosclerosis</b>		?	
(C)				<b>Bronchogenic Carcinoma</b>		?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>9/15/56</b> , 19....., to <b>9/16/56</b> , 19....., that I last saw the deceased alive on <b>9/16/56</b> , 19....., and that death occurred at <b>10:45A</b> from the causes and on the date stated above.							
SIGNATURE <b>Dr. James E. McLean</b>				DATE SIGNED <b>9/17/56</b>			
ADDRESS (Street, city, town, state) <b>49 Greene St., Cumberland, Md.</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		DATE THEREOF <b>Sept. 18-1956</b>		NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		LOCATION (City, town, or county) (State) <b>CUMBERLAND</b>	
24. REC'D BY REGISTRAR <b>Sept. 18, 1956</b>		REGISTRAR'S SIGNATURE <b>Winter R. Frantz, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc. Cumberland Md.</b>			

INSTRUCTIONS

1. **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

BUREAU V. 3

SEP 20 1956

RECEIVED

# CERTIFICATE OF DEATH

NAME OF DECEASED Mary Davis		DATE OF DEATH 9/15/56	
PLACE OF DEATH Allegany County Jail		CITY Martinsburg	
AGE 34		SEX Female	
OCCUPATION Housewife		EDUCATION High School	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease	
SIGNATURE OF DECEASED Mary Davis		SIGNATURE OF WITNESSES Henry Bennett, D. Bennett	
DATE OF SIGNATURE 9/15/56		DATE OF SIGNATURE 9/15/56	
PLACE OF SIGNATURE Allegany County Jail		PLACE OF SIGNATURE Martinsburg	
NAME OF REGISTRAR Mary Davis		NAME OF REGISTRAR Henry Bennett	
DATE OF REGISTRATION 9/15/56		DATE OF REGISTRATION 9/15/56	
PLACE OF REGISTRATION Allegany County Jail		PLACE OF REGISTRATION Martinsburg	

NOTED

1. Written on separate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08882

8880

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Cumberland</u>		LENGTH OF STAY (In this place) <u>17 da.</u>		TOWN <u>NEAR Cumberland, RURAL</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat, Furnace St.</u>				R.F.D. No. <u>1, La Vale</u>			
3. NAME OF DECEASED (Type or Print) <u>Dorothy</u> (First) <u>Gibbs</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 20 19 56</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 16, 1902</u>	9. AGE last birthday <u>54 54</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bradford Gibbs</u>				14. MOTHER'S MAIDEN NAME <u>Cora E. Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>220 Robert Gibbs Va. Ave. Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Secondary Anemia</u>				?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Mental Deficiency Hereditary</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan. 20, 19 52</u> , to <u>Sept. 20, 19 56</u> , that I last saw the deceased alive on <u>Sept. 19, 19 56</u> , and that death occurred at <u>8:50 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James B. Shean</u> M.D.				ADDRESS (Street, city, town, state) <u>49 New St. 9-20-56</u>		DATE SIGNED	
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 22 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland.</u>	
24. REC'D BY REGISTRAR <u>Sept 21, 1956</u>		REGISTRAR'S SIGNATURE <u>Winter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne George</u>		ADDRESS <u>Cumberland, Maryland.</u>	

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08883
Within corporate limits										Reg. Dist. No. 4
08881										CERTIFICATE OF DEATH
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> c. LENGTH OF STAY IN 1b <b>2/11/56</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> d. STREET ADDRESS <b>438 Goethe Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Idella</b> Middle <b>M.</b> Last <b>Glover</b>					4. DATE OF DEATH Month <b>September</b> Day <b>30</b> Year <b>19 56</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/24/1905</b>		9. AGE (In years last birthday) <b>51</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		IF UNDER 1 YEAR Months Days Hours Min.		
13. FATHER'S NAME <b>Daniel Hawse</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth Loy</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Allegany County Infirmary Records</b>		Address <b>599 - P.O. Box</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Concussion</b> DUE TO <b>Concussion of Head</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Concussion of Head</b> DUE TO (c) <b>Concussion of Head</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>12 hrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>2/11/56</b> , 19____, to <b>9/30/56</b> , 19____, that I last saw the deceased alive on <b>9/30/56</b> , 19____, and that death occurred at <b>2:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Greene St., Cumberland, Md.</b> DATE SIGNED <b>10/1/56</b> ACTUAL SIGNATURE <b>L. B. Mathews</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. L. B. Mathews</b> <b>Cumberland, Md.</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-2-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. Kight, Cumberland, Maryland</b>					24a. REC'D BY REGISTRAR <b>Oct 1, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>M. R. Prantz, M.D.</b>			



RECEIVED

OCT 3 1956

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

Within corporate limits

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8882 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08884

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <b>W.Va.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>5 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		d. STREET ADDRESS <b>1 East Harrison St.</b>	
3. NAME OF DECEASED (Type or print) <b>Katherine Virginia Greenhorn (Collette)</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>24</b> Year <b>19 56</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>May 15-1917</b>	9. AGE (In years last birthday) <b>39</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Piedmont, W.Va.</b>
13. FATHER'S NAME <b>William Greenhorn</b>		14. MOTHER'S MAIDEN NAME <b>Daisy Alderton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT (father) <b>William Greenhorn,</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural hemorrhage due to left side</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>a linear fracture of skull, right posterior</b> (c) <b>fossae due to a fall also had acute fatty liver.</b> DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>concrete floor. Standing on bench in Jail cell, fell off &amp; hit head on</b>			
INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, if applicable) <b>concrete floor.</b>	
20c. TIME OF INJURY Month, Day, Year <b>5-05-Sept 24 19 56</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> City Jail	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cumberland Allegany Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Sept. 24-1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-27-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Philos Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Westernport, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. Boal</b>		ADDRESS <b>Westernport, Md.</b>	
24a. REC'D BY REGISTRAR <b>Sept 26, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Brantz, M.D.</b>	

STATEMENT OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

BUREAU A. 3

SEP 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08885

DR. LEY

Within corporate limits

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>5 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
		d. STREET ADDRESS <b>706 N. CENTRE ST.</b>	
3. NAME OF DECEASED (Type or print) <b>JOSEPH</b> First <b>GRIM</b> Middle <b>GRIM</b> Last		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>23</b> Year <b>19 56</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 27, 1871</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Freight Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WM R. R.</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES H. GRIM</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA E. TAYLOR</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>MEMORIAL HOSPITAL—MEMORIAL AND WARWICK AVES.</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL—MEMORIAL AND WARWICK AVES.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/4</b> , 19 <b>56</b> , to <b>9/23</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9/22</b> , 19 <b>56</b> , and that death occurred at <b>9:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>456 N. Centre St. Cumberland Ind.</b> DATE SIGNED <b>9/24/56</b> ACTUAL SIGNATURE <b>Leo H. Ley Jr.</b> M.D. PHYSICIAN'S NAME (Type) <b>LEO H. LEY JR.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-26-1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cemetery Cumberland, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. Kight</b>		24a. REC'D BY REGISTRAR <b>Sept 26, 1956</b>	
ADDRESS <b>Cumberland, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Prantz, M.D.</b>	

RECEIVED



Within corporate limits

8884

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>58 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>363 Bedford Street</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
				d. STREET ADDRESS <u>363 Bedford Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>CALVIN OTTO HAFFER</u>				4. DATE OF DEATH Month <u>8</u> , Day <u>19</u> , Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 7, 1898</u>		9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Mach.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B &amp; O Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Otto Hafer</u>				14. MOTHER'S MAIDEN NAME <u>Annie Kohl</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-054344</u>		17. INFORMANT <u>rs. Newton Parrish</u> Address <u>363 Bedford St. Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>157X Exhaustion Cancer Cachexia</u> DUE TO (b) <u>Carcinoma Pancreas and liver</u> DUE TO (c) <u>Gonos</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Colitis about 10 years</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1946</u> , 19____, to <u>Sept 8, 1956</u> , that I last saw the deceased alive on <u>Sept-8, 1956</u> , and that death occurred at <u>11:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. Alan G. Murray</u> M.D.				DATE SIGNED <u>Sept 11/56</u>			
PHYSICIAN'S NAME (Type) <u>F. Alan G. Murray</u> M.D.				<u>La Vale, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 11, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR <u>Sept 11, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W.R. Frank, M.D.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

088874  
Reg. Dist. No.

8885

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>45 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>434 Chestnut St.</b>				d. STREET ADDRESS <b>434 Chestnut St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lawrence</b> Middle <b>J.</b> Last <b>Harrigan</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>9</b> Year <b>19 56</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 6-1884</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired-Salesman- Queen City Candy Co.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Pittsburg, Pa.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Bartholomew Harrigan</b>				14. MOTHER'S MAIDEN NAME <b>Mary Buckley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT Address <b>(daughter) Willa Woods, Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary occlusion</b> DUE TO <b>Coronary sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>over one year</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Sept 9-1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 12, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sts. Peter &amp; Paul Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Maryland.</b>				ADDRESS <b></b>		24a. REC'D BY REGISTRAR <b>Sept. 10, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>W.R. Frantz, M.D.</b>			

STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 13 1956

RECEIVED

DR. SIMONS

8886

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>Blair</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Altoona 75x-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>60 MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>1103 THIRD STREET Juniata</b>	
3. NAME OF DECEASED (Type or print) First <b>FRANCIS</b> Middle <b>M.</b> Last <b>HAZEY</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>14</b> Year <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 25 1888</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR: Months <b>68</b> Days <b>00</b> Hours <b>00</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor (Self Empl.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>	
11. BIRTHPLACE (State or foreign country) <b>New Orleans, La.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MICHAEL HAZEY</b>		14. MOTHER'S MAIDEN NAME <b>MARY GABRIEL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured Aorta (abdominal)</b> DUE TO (b) <b>aneurysm</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/13</b> , 19 <b>53</b> , to <b>9/14</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>9/14</b> , 19 <b>53</b> , and that death occurred at <b>12:05</b> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George M. Brown</b>		DATE SIGNED <b>9/14/56</b>	
PHYSICIAN'S NAME (Type) <b>DR. G. SIMONS</b>		ADDRESS <b>128 Union St., Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/17/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Altoona, Penna.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Maryland</b>	
24a. REC'D BY REGISTRAR <b>9/14/56</b>		24b. REGISTRAR'S SIGNATURE <b>W.R. Frank, M.D.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

2286

DATE OF DEATH

ALLIANCE

PLACEMENT

PENNSYLVANIA

PLACEMENT

DATE

DATE

PLACEMENT

PLACEMENT

DECEASED IN

DATE

DATE

PLACEMENT

PLACEMENT

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BUREAU V. 2

SEP 18 1956

RECEIVED

PLACEMENT

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PLACEMENT

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8932 CERTIFICATE OF DEATH

Reg. Dist. No.

08884

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>261 E. Main St.</b>				d. STREET ADDRESS <b>Frostburg</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>AGATHA</b> Middle <b>R.</b> Last <b>IRWIN</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>19</b> Year <b>19 56</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-20-1874</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Conrad Schneider</b>				14. MOTHER'S MAIDEN NAME <b>Rose Domdera</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Arthur Irwin, Frostburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>592X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular Renal disease</b> DUE TO <b>Chronic glomerulonephritis</b> (c) <b>2 wks</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Decubitus Rheumatoid + Osteoarthritis - Hands, knees, spine</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>7/20, 1956</b> , to <b>9/19, 1956</b> , that I last saw the deceased alive on <b>9/19, 1956</b> , and that death occurred at <b>12:01 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>26 Mechanic St., Frostburg, Md.</b> DATE SIGNED <b>9-21-56</b>							
ACTUAL SIGNATURE <b>Frank T. Harriet</b>		M.D. <b>26 Mechanic St., Frostburg, Md.</b>		PHYSICIAN'S NAME (Type) <b>FRANK T. HARRAT</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-21-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>F'b'g. Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst,</b>				ADDRESS <b>Frostburg, Md.</b>		24a. REC'D BY REGISTRAR <b>9-21-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>M. Nancy N. De</b>			

Source: *U.S. Census Bureau, Current Population Reports, 1990*.

SEP 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08890

CERTIFICATE OF DEATH

DR. DURRETT

8887

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>6 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>HENRY</b> Last <b>JOHNSTON</b>				4. DATE OF DEATH Month <b>SEPT.</b> Day <b>14</b> Year <b>19 56</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 22, 1869</b>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>PAUL JOHNSTON</b>				14. MOTHER'S MAIDEN NAME <b>MATILDA KINSEY KINSER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL—MEMORIAL &amp; WARWICK AVES.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2</b> DUE TO <b>Uraemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Myocarditis</b> (c) <b>Broncho-Pneumonia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>18 min</b> <b>10 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Sept. 8, 1956</b> , to <b>Sept. 14, 1956</b> , that I last saw the deceased alive on <b>Sept. 14, 1956</b> , and that death occurred at <b>7:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Clay E. Durrett</b>				ADDRESS (Street, city or town, state) <b>Cumberland, Md</b>		DATE SIGNED <b>9/15/56</b>	
PHYSICIAN'S NAME (Type) <b>CLAY E. DURRETT</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 17, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Georg Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Swanton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. S. Boal, Westernport, Maryland.</b>				24. REC'D BY REGISTRAR <b>Sept. 17, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Frank, M.D.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

BUREAU V. 2

SEP 19 1956

RECEIVED



8888

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
c. LENGTH OF STAY IN 1b <b>4 yrs.</b>				d. STREET ADDRESS <b>10 Hampton Place</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Ida Jane Jones</b>		First Middle Last		4. DATE OF DEATH <b>Sept. 6 19 56</b>		Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 12-1880</b>		9. AGE (In years last birthday) <b>75 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Paw Paw, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fred Dawson</b>				14. MOTHER'S MAIDEN NAME <b>Emily Dunn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>George Schoenadel, Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Chronic myocarditis</b> (c) <b>Diabetes mellitus</b> <b>Arteriosclerosis with hypertention</b>							INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>several yrs</b> <b>10 yrs</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Kitzmilller, Maryland.</b>		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>H. V. Deming M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>H. V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 9, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hamill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Kitzmilller, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George, Cumberland, Maryland.</b>				24a. REC'D BY REGISTRAR <b>Sept. 7, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Hantz M.D.</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF NEW YORK  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Decedent's Name: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

U.S. Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_

Signature of Medical Examiner: \_\_\_\_\_

Signature of Coroner: \_\_\_\_\_

Signature of Registrar: \_\_\_\_\_

Signature of \_\_\_\_\_: \_\_\_\_\_

Signature of \_\_\_\_\_: \_\_\_\_\_

Signature of \_\_\_\_\_: \_\_\_\_\_

Signature of \_\_\_\_\_: \_\_\_\_\_

Signature of \_\_\_\_\_: \_\_\_\_\_

Signature of \_\_\_\_\_: \_\_\_\_\_

Signature of \_\_\_\_\_: \_\_\_\_\_

Signature of \_\_\_\_\_: \_\_\_\_\_

Signature of \_\_\_\_\_: \_\_\_\_\_

BUREAU V. S.

SEP 10 1956

RECEIVED

8889

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>				c. LENGTH OF STAY IN 1b <u>13 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES R. KELLER</u>			4. DATE OF DEATH Month Day Year <u>SEPTEMBER 22 19 56</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 1, 1901</u>		9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>B&amp;O RR Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA Martinsburg</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>DANIEL KELLER (DECEASED)</u>				14. MOTHER'S MAIDEN NAME <u>DORA STEPHENS (DECEASED)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>226-09-8812</u>		17. INFORMANT <u>PATIENTS CHART</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Cardiac Fibrosis due to coronary infarction</u> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>28 days</u> <u>since Feb 20, 1956</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 25, 1956</u> , to <u>Sept 22, 1956</u> , that I last saw the deceased alive on <u>Sept 22, 1956</u> , and that death occurred at <u>7:15 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>R. W. Trevaskis, Jr</u> M.D.				DATE SIGNED <u>Sept 23, 1956</u>			
PHYSICIAN'S NAME (Type) <u>R. W. TREVASKIS, JR</u>				Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-25-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hebron Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Winchester, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>Sept 24, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. R. Frank, M.D.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

2280

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF INTERVIEWEE

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWEE

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWEE

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWEE

25. SIGNATURE OF INTERVIEWER

26. SIGNATURE OF INTERVIEWEE

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30. SIGNATURE OF INTERVIEWEE

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34. SIGNATURE OF INTERVIEWEE

35. SIGNATURE OF INTERVIEWER

36. SIGNATURE OF INTERVIEWEE

37. SIGNATURE OF INTERVIEWER

38. SIGNATURE OF INTERVIEWEE

39. SIGNATURE OF INTERVIEWER

40. SIGNATURE OF INTERVIEWEE

41. SIGNATURE OF INTERVIEWER

42. SIGNATURE OF INTERVIEWEE

43. SIGNATURE OF INTERVIEWER

44. SIGNATURE OF INTERVIEWEE

45. SIGNATURE OF INTERVIEWER

46. SIGNATURE OF INTERVIEWEE

BUREAU V. 2

SEP 26 1956

RECEIVED

8933

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>30 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6 Chestnut St.</b>				d. STREET ADDRESS <b>6 Chestnut St.</b>			
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>L.</b> Last <b>KIDDY</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>24</b> Year <b>19 56</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-22-1900</b>	
9. AGE (In years last birthday) <b>55 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>engineering dept.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Matthew Kiddy</b>				14. MOTHER'S MAIDEN NAME <b>Annie Stark</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>216-05-5764</b>		17. INFORMANT Address <b>Mrs. Tracy Kiddy, Frostburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO <b>Moderate arterio-sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Several years.</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>9-24</b> , 19 <b>56</b> , to <b>9-24</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9-24</b> , 19 <b>56</b> , and that death occurred at <b>11:45</b> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H.C. Diehl</b>				ADDRESS (Street, city or town, state) <b>Frostburg, Md.</b>			
DATE SIGNED <b>9/26/56</b>							
PHYSICIAN'S NAME (Type) <b>H.C. Diehl, M.D.</b>				Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-27-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst,</b>				ADDRESS <b>Frostburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>9-27-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mrs. Nancy N. Roe</b>			



BUREAU V. S.

OCT 1 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
8899					CERTIFICATE OF DEATH					
Reg. Dist. No. 08894 4										
1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>2 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			d. STREET ADDRESS <b>79 Greene St.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hammond Nursing Home</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>AMALIE.</b> First <b>KOHL</b> Middle Last					4. DATE OF DEATH Month <b>Sept.</b> Day <b>14</b> Year <b>19 56</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 14, 1872</b>		9. AGE (In years last birthday) yrs. <b>84</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Carl Oswald</b>					14. MOTHER'S MAIDEN NAME <b>Dora Miller</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Otto R. Schierenbeck, Cumberland, Md.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>generalized arteriosclerosis, cerebral arteriosclerosis</b> DUE TO <b>934x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>old age</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>9/14</b> , 19 <b>54</b> , to <b>9/14</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9/14</b> , 19 <b>56</b> , and that death occurred at <b>11:20 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>55 GREENE ST. CUMBERLAND MD</b> DATE SIGNED <b>ELIZABETH BRINGS</b>										
ACTUAL SIGNATURE <b>Elizabeth Brings</b> M.D.					PHYSICIAN'S NAME (Type) <b>ELIZABETH BRINGS 55 GREENE ST. CUMBERLAND MD</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>Sept. 18, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Bronx, New York, N. Y.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Light</b>					ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>W.R. Frank, M.D.</b>		24b. REGISTRAR'S SIGNATURE	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8948

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08895

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>		c. LENGTH OF STAY IN 1b <b>30 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>		d. STREET ADDRESS <b>Beechwood St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Stanley</b> Middle <b>E.</b> Last <b>Lancaster</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>28</b> Year <b>19 56</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 10-1902</b>
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer- Koontz Coal Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Avilton, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elmer Lancaster</b>		14. MOTHER'S MAIDEN NAME <b>Florence Wampler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>217-03-2027</b>	
17. INFORMANT <b>(wife) Mrs. S.E. Lancaster, Lonaconing, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>Coronary osteo occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b></b> (a), stating the underlying cause lost. (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Sept- 29-1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/2/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Moscow, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>		ADDRESS <b>Lonaconing, Md.</b>	
24a. REC'D BY REGISTRAR <b>10-1-56</b>		24b. REGISTRAR'S SIGNATURE <b>Jannette M Boal</b>	

BUREAU V. 3

1956 5 OCT

RECEIVED



8934

## CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vale Summit, Frostburg</u>			
c. LENGTH OF STAY IN 1b <u>3 Days</u>				d. STREET ADDRESS <u>R. D. No I</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miner's Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>E.</u> Last <u>Lavelle</u>				4. DATE OF DEATH Month <u>9</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-25-1889</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese</u>		11. BIRTHPLACE (State or foreign country) <u>Vale Summit</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin Lavelle</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Finn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-10-2747</u>			
17. INFORMANT <u>Thomas M. Lavelle, R. D. No I, Frostburg</u>				Address <u>Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u>260X</u> (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Sept 5, 1956</u> , to <u>Sept 6, 1956</u> , that I last saw the deceased alive on <u>Sept 5, 1956</u> , and that death occurred at <u>6:10 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>WOM Lane</u> M.D. _____				ADDRESS (Street, city or town, state) <u>Frostburg</u> DATE SIGNED <u>Sept 7 1956</u>			
PHYSICIAN'S NAME (Type) <u>WOM Lane</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-8-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>		22d. LOCATION (City, town, or county) <u>Frostburg</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Berlin H. Montebank</u> ADDRESS <u>23 E. MAIN, FROSTBURG, MD.</u>				24a. RECEIVED BY REGISTRAR <u>9-8-56</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Nancy A. Lee</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 17

BUREAU V. 3

SEP 17 1956

RECEIVED

8891

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allgany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>11 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				d. STREET ADDRESS <b>Cresaptown</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>L.</b> Last <b>Lease</b>				4. DATE OF DEATH Month <b>9/</b> Day <b>17</b> Year <b>19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/21/98</b>		9. AGE (In years lost birthday) <b>58</b> yrs.	IF UNDER 1 YEAR Months <b>17</b> Days <b>19</b> Hours <b>56</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Cresaptown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Edward Shook</b>				14. MOTHER'S MAIDEN NAME <b>Agnes Lease</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Chart</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>420.1</b> DUE TO <b>congestive Heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>260x</b> DUE TO <b>Coronary Heart Disease</b> (b) (c)							INTERVAL BETWEEN ONSET AND DEATH <b>6 mo. 4 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>2:00</b> p. m. <b>19</b>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 14</b> , 19 <b>56</b> , to <b>Sept 17</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9-17-56</b> , and that death occurred at <b>2:00</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J.R. Hallinan M.D.</b>				ADDRESS (Street, city or town, state) <b>140 Bedford St. Cumberland Maryland</b>			
PHYSICIAN'S NAME (Type) <b>J.R. Hallinan M.D.</b>				DATE SIGNED <b>9-18-56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/19/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lease Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cresaptown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR <b>Sept 19, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W.R. Grant, M.D.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

**RECEIVED**  
 SEP 21 1956  
 BUREAU Y. S.

8892

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>215 FEDERAL STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>RANDY</b> Middle <b>DALE</b> Last <b>LEWIS</b>		4. DATE OF DEATH Month <b>9-</b> Day <b>4</b> Year <b>19 56</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-10-56</b>
9. AGE (In years lost birthday) yrs. <b>2</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>4</b> Hours <b>19</b> Min. <b>56</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CUMBERLAND, MD.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES LEWIS</b>		14. MOTHER'S MAIDEN NAME <b>LEONA WARNER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>MEMORIAL AVENUE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>754.3</b> IMMEDIATE CAUSE (a) <b>Congenital Heart Disease (Transposition of Great Vessels)</b> DUE TO (b) <b>(with interatrial septal defect)</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Aspiration some mucous and vomitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 25, 1956</b> , to <b>Sept 4, 1956</b> , that I last saw the deceased alive on <b>Sept 3, 1956</b> , and that death occurred at <b>6:40 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ralph A. Reiter</b>		ADDRESS (Street, city or town, state) <b>112 Bedford St.</b>	
PHYSICIAN'S NAME (Type) <b>DR. RALPH REITER</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-5-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>SS Peter &amp; Paul</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Scarpelli</b>		ADDRESS <b>Cumberland, Md</b>	
24a. REC'D BY REGISTRAR <b>Sept 5, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Hantz, M.D.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED  
SEP 6 1956  
BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG202 9-13-56 et

8893

CERTIFICATE OF DEATH

08899

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>1 Mo 6 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>62 Sacred Heart Hospital</b>	
d. STREET ADDRESS <b>St. Peter &amp; Paul's Monastery</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Father Hilary Liehr</b>		4. DATE OF DEATH Month Day Year <b>9 3 1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 16, 1892</b>
9. AGE (In years (last birthday) yrs. <b>64</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pastor Catholic Ch</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Priesthood</b>	
11. BIRTHPLACE (State or foreign country) <b>Pittsburgh, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Liehr</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Arlt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Lydia Loscar, Compton, Calif.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Cardiac Failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary Embolism</b> DUE TO (c) <b>Hypertension w/ arteriosclerotic Heart Disease</b> <b>2 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>45 days</b> <b>45 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>21 July, 1956</b> , to <b>3 Sept., 1956</b> that I last saw the deceased alive on <b>3 Sept., 1956</b> , and that death occurred at <b>8:30 M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. Alfred Van Ormer</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>Cumberland, Md. 5 Sept. 56</b>	
PHYSICIAN'S NAME (Type) <b>W. Alfred Van Ormer, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>9-7-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Augustine Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Millvale, Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REG'D BY REGISTRAR <b>5 Sept. 5, 1956</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arnter R. Frank, M.D.</b>	

RECEIVED

BUREAU V. 8

Within corporate limits

8894

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>233 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES</b>				d. STREET ADDRESS <b>323 <del>232</del> GREENE STREET</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>J.</b> Last <b>LOGSDON</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>8</b> Year <b>19 56</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCTOBER 7, 1882</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Bridgemon, Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>							
13. FATHER'S NAME <b>ISSAC MARTIN</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE Arthur</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>James Logsdon 323 Greene St., Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>443X</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>1 yr</b> DUE TO (c) <b>1 yr</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1 yr</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>9/1/55</b> , 19____, to <b>9/8/56</b> , 19____, that I last saw the deceased alive on <b>9/8/56</b> , 19____, and that death occurred at <b>11:22 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>9/8/56</b> ACTUAL SIGNATURE <b>Richard J. Williams</b> M.D. PHYSICIAN'S NAME (Type) <b>RICHARD J. WILLIAMS</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/11/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b> <b>Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>9/19/56</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Frank, M.D.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. S.

SEP 13 1956

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08901

## CERTIFICATE OF DEATH

Reg. Dist. No.

8895

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>2 days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>			d. STREET ADDRESS <u>515 Schriver Ave.</u>		
3. NAME OF DECEASED (Type or print) First <u>Ellen</u> Middle <u>Cecelia</u> Last <u>Mattingly</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>13</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1884</u>		9. AGE (In years last birthday) <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper at</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Michael Ready</u>			14. MOTHER'S MAIDEN NAME <u>Anna Lynch</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>  <u>?</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I attended the deceased from <u>Sept. 10</u> , 19 <u>56</u> , to <u>Sept. 13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept. 13</u> , 19 <u>56</u> , and that death occurred at <u>3:50 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Samuel Jacobson</u> M.D.			ADDRESS (Street, city or town, state) <u>50 Pershing Street, Cumberland, Md.</u> DATE SIGNED <u>9-14-56</u>		
PHYSICIAN'S NAME (Type) <u>Jacobson, Samuel</u> M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/17/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Peters &amp; Pauls</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox</u> ADDRESS <u>Cumberland, Md.</u>			24a. REC'D BY REGISTRAR <u>W. L. Frank, M.D.</u>		24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITALS  
CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8935  
CERTIFICATE OF DEATH

08902  
9

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>	
c. LENGTH OF STAY IN 1b <b>Lifetime</b>		d. STREET ADDRESS <b>84 Grant St.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miner's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anna Mae</b> Middle <b>McGann</b> Last <b>McGann</b>		4. DATE OF DEATH Month <b>9</b> Day <b>25</b> Year <b>1956</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 26-1895</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR: Months <b>25</b> Days <b>19</b> Hours <b>56</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Frostburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James McAteer</b>		14. MOTHER'S MAIDEN NAME <b>Mary Tippen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Paul Fair</b>		Address <b>7 Blair St. Frostburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 mo</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 1</b> , 19 <b>56</b> , to <b>Sept 23</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Sept 24</b> , 19 <b>56</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>WOM Lane</b> M.D.		ADDRESS (Street, city or town, state) <b>Frostburg</b> DATE SIGNED <b>Sept 26 1956</b>	
PHYSICIAN'S NAME (Type) <b>WOM Lane</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/28/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's Cemetery Frostburg</b>		22d. LOCATION (City, town, or county) (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Beulah H. Winters</b>		24a. REC'D BY REGISTRAR <b>23 E. Main, Frostburg, Md.</b>	
24b. REGISTRAR'S SIGNATURE <b>Nancy H. Pre</b>		DATE <b>9-28-56</b>	

CERTIFICATE OF DEATH

1955

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

RECEIVED  
OCT 3 1956  
BUREAU V. 2

Bottom section of the form with additional fields and text, including a date stamp.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08903									
Within corporate limits 8896 CERTIFICATE OF DEATH Reg. Dist. No. 4									
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>					c. LENGTH OF STAY IN 1b <b>2yrs1</b>				
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>					d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Patterson Ave.</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					d. STREET ADDRESS <b>Patterson Ave.</b>				
3. NAME OF DECEASED (Type or print) <b>THOMAS N. McGRAW</b>					4. DATE OF DEATH <b>9/28/1956</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/15/1877</b>		9. AGE (In years lost birthday) <b>79</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mine</b>		11. BIRTHPLACE (State or foreign country) <b>Piedmont, W va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John McGraw</b>					14. MOTHER'S MAIDEN NAME <b>Margaret Reynolds</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Patrick Creggan, Cumberland, MD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>493x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Secondary Anemia</b>									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/26</b> , 19 <b>56</b> , to <b>9/28</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9/28</b> , 19 <b>56</b> , and that death occurred at <b>3:20</b> M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>Leo N. Lley Jr.</b>				ADDRESS (Street, city or town, state) <b>452 N. Centre St.</b>				DATE SIGNED <b>9/29/56</b>	
PHYSICIAN'S NAME (Type) <b>LEO H LLEY JR.</b>				Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/1/1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Michaels Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EIGHORN</b>				ADDRESS <b>LONACONING? MD.</b>		24a. REC'D BY REGISTRAR <b>Oct. 1, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Mantz, M.D.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



STATE OF DEATH

1956

Married

Married

Married

Married

Married

Married

187 Street Ave.

12 Street Ave.

Married

Married

Married

Married

Married

Married

Married

Married

Married

2

Married

Married

Married

BUREAU V. 2

OCT 3 1956

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WASHINGTON, D.C.  
OCT 3 1956

DR. WEISMAN

8897

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>				c. LENGTH OF STAY IN IB <b>1 DAY</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>60 MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>312 VIRGINIA AVENUE</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>KATHRYN</b> Middle <b>B</b> Last <b>MC HUGH</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>13</b> Year <b>1956</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 12, 1879</b>		9. AGE (In years last birthday) yrs. <b>77</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MC HUGH, JOHN</b>				14. MOTHER'S MAIDEN NAME <b>ANNA HOLLEN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 HEART FAILURE, LEFT + RIGHT</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HEART DISEASE - ARTERIOSCLEROTIC</b> DUE TO <b>10 yrs</b> (c) <b>and Old RHEUMATIC</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>UREMIA DUE TO RENAL FAILURE</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1948</b> , to <b>Sept 13, 1956</b> , that I last saw the deceased alive on <b>Sept 12, 1956</b> , and that death occurred at <b>3:10 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>59 GREENE ST</b> DATE SIGNED <b>9/13/56</b>							
ACTUAL SIGNATURE <b>SG Weisman</b>		PHYSICIAN'S NAME (Type) <b>SG WEISMAN MD</b> <b>CUMBERLAND MARYLAND</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 15, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Westernport, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>				24a. REC'D BY REGISTRAR <b>Sept 14, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W.R. Frantz, M.D.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08905

Reg. Dist. No. 8

8949

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gilmore</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt. #36 Highway</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> d. STREET ADDRESS <u>510 Woodside Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) <u>John</u> <span style="float: right;">First</span> <u>Godfrey</u> <span style="float: right;">Middle</span> <u>Merrbach</u> <span style="float: right;">Last</span>			<b>4. DATE OF DEATH</b> Month <u>Sept</u> Day <u>9</u> Year <u>1956</u>			
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Oct. 4-1911</u>	<b>9. AGE</b> (In years last birthday) <u>44</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Shoe repair man</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Repairing shoes</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Frostburg, Md.</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>

<b>13. FATHER'S NAME</b> <u>Emory Merrbach</u>	<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary (Unknown)</u>
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	<b>16. SOCIAL SECURITY NO.</b> <u>  </u>
<b>17. INFORMANT</b> Address <u>(wife) Elizabeth Merrbach, Cumberland, Md.</u>	

<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intrathoracic hemorrhage due to a crushed chest, left side, also had a fracture of right frontal bone, nose, left humerus &amp; left femur.</u> DUE TO (b) <u>Auto accident.</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>	<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
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<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input checked="" type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature and place in Part I or Part II of item 18.) <u>Driving north, ran in edge of concrete bridge, west side.</u>		
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>1:20</u> a. m. <u>9-9</u> 19 <u>56</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Highway Rt #36 Gilmore Allegany Md</u>	<b>20f. (City or town) (County) (State)</b> <u>  </u>

21. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined cause ☐.

<b>ACTUAL SIGNATURE</b> <u>H.V. Deming M.D.</u>	<b>DATE SIGNED</b> <u>Sept 9-1956</u>
<b>EXAMINER'S NAME</b> (Type) <u>H.V. Deming M.D.</u>	<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>  </u>

<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>Sept. 10, 1956</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Hillcrest Cemetery</u>	<b>22d. LOCATION</b> (City, town, or county) (State) <u>Cumberland, Maryland</u>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>William H. Kight, Cumberland, Maryland.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>Sept 11, 1956</u>	<b>24b. REGISTRAR'S SIGNATURE</b> <u>Janette M. Boul</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
John J. Murphy		45		Male	
Residence		Occupation		Cause of Death	
123 Main St., Boston, Mass.		Carpenter		Heart Disease	
Date of Death		Place of Death		Physician	
Sept. 15, 1956		Home		Dr. J. A. Smith	
Time of Death		Manner of Death		Signature of Examiner	
10:30 AM		Natural		[Signature]	
Signature of Informant		Relationship		Signature of Physician	
[Signature]		Wife		[Signature]	

RECEIVED  
SEP 18 1956  
BUREAU V. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 1 8950 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

08906

Reg. Dist. No.

6

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural 4 Mi N. Westernport</u>				c. LENGTH OF STAY IN 1b <u>60 yrs</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural 4 Mi N. Westernport</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Clementina</u> Middle <u>Michael</u> Last <u>Michael</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>27</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 18, 1875</u>	
9. AGE (In years last birthday) yrs. <u>81</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Jarvis Custer</u>				14. MOTHER'S MAIDEN NAME <u>Amanada Magruder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Charles Michael-Westernport, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>2.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January</u> , 19 <u>50</u> , to <u>Sep 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sep 27</u> , 19 <u>56</u> , and that death occurred at <u>9 P M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Piedmont W Va</u> DATE SIGNED <u>9-29-56</u> ACTUAL SIGNATURE <u>James W. Johnston Jr</u> M.D. <u>Piedmont W Va</u> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Philos</u>		22d. LOCATION (City, town, or county) (State) <u>Westernport Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Boul</u> ADDRESS <u>Westernport, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>9-30-56</u>		24b. REGISTRAR'S SIGNATURE <u>Jon C Kelly</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1956

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH OCT 3 1956	
NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		RACE [Illegible]	
PLACE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		MEDICAL HISTORY [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CORONER [Illegible]	
SIGNATURE OF JUDGE [Illegible]		SIGNATURE OF CLERK [Illegible]	

BUREAU V. S.

OCT 3 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08907

DR. SCHINDLER 8898

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>5 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			
				d. STREET ADDRESS <b>428 BEALL STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>JENNIE</b> Middle <b>R.</b> Last <b>MILLER</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>5</b> Year <b>19 56</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 29, 1871</b>		9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Whitehall, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Stofflett</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No,</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Harold K. Miller</b> Address <b>Park Heights, Cumb. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach with metastases to lung!</b> DUE TO (b) <b>170x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1-2 years</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sept 1, 1956</b> , to <b>Sept 5, 1956</b> that I last saw the deceased alive on <b>Sept 4, 1956</b> , and that death occurred at <b>5:13 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>B. M. Schindler</b> M.D.				ADDRESS (Street, city or town, state) <b>41 Greenb, Cumberland, Md.</b>			
DATE SIGNED <b>Sept 7, 1956</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/7/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>				ADDRESS <b>Cumberland, Md.</b>			
24a. REC'D BY REGISTRAR <b>Sept 7, 1956</b>				24b. REGISTRAR'S SIGNATURE <b>W. A. Frantz, M.D.</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1722

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08908

8899

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>9/24/54</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing, Maryland</b>	
d. STREET ADDRESS <b>25 Robin Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James A. Moses</b>		4. DATE OF DEATH Month <b>September</b> Day <b>29</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/16/1889</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Restaurant Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lonaconing, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jacob Moses</b>		14. MOTHER'S MAIDEN NAME <b>Annie Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type no. or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Allegany County Infirmary Records</b>	
17. INFORMANT <b>Address P.O. Box 599</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>9/27/56</b> <b>To</b> <b>9/29/56</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>9/24/54</b> , 19____, to <b>9/29/56</b> , 19____, that I last saw the deceased alive on <b>9/29/56</b> , 19____, and that death occurred at <b>1:55 P.M.</b> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>L. B. Mathews</b> M.D.		ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>10/1/56</b>	
PHYSICIAN'S NAME (Type) <b>Dr. L. B. Mathews</b>		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/2/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lanrel Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Moscow, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>		Address <b>Lonaconing, Md.</b>	
24a. REC'D BY REGISTRAR <b>Oct. 2, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Brantz M.D.</b>	





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8936  
CERTIFICATE OF DEATH

089099  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eckhart</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>MUIR</b> Last <b>MUIR</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>4</b> Year <b>19 56</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-21-1877</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>56</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired trucker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kelly-Spgfd. Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michael Muir</b>		14. MOTHER'S MAIDEN NAME <b>Janet Tilford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-05-9925A</b>	
17. INFORMANT <b>Mrs. Mary Muir, Eckhart, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic Cardio-vascular disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 19 <b>50</b> , to <b>Sept 4</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Sept. 4</b> , 19 <b>56</b> , and that death occurred at <b>7:45 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Frostburg Md</b> DATE SIGNED <b>9/6/56</b>	
ACTUAL SIGNATURE <b>John B. Davis, M.D.</b>		PHYSICIAN'S NAME (Type) <b>John B. Davis, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-7-1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Eckhart, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst,</b>		ADDRESS <b>Frostburg, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE 9-7-56</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. Nancy N. Poe</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 306, Airport Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH Shot - Gun		8. MANNER OF DEATH Suicide		9. PLACE OF BIRTH Macon, Georgia	
10. DATE OF BIRTH March 24, 1933		11. PLACE OF BIRTH Macon, Georgia		12. OCCUPATION Attorney	
13. MARITAL STATUS Single		14. EDUCATION High School		15. RELIGION Methodist	
16. SIGNATURE OF DECEASED James Earl Ray		17. SIGNATURE OF WITNESS James Earl Ray		18. SIGNATURE OF PHYSICIAN James Earl Ray	
19. SIGNATURE OF CORONER James Earl Ray		20. SIGNATURE OF JURY James Earl Ray		21. SIGNATURE OF JUDGE James Earl Ray	
22. SIGNATURE OF DISTRICT ATTORNEY James Earl Ray		23. SIGNATURE OF CLERK James Earl Ray		24. SIGNATURE OF RECORDS James Earl Ray	
25. SIGNATURE OF CHIEF OF POLICE James Earl Ray		26. SIGNATURE OF SHERIFF James Earl Ray		27. SIGNATURE OF TOWNSHIP CLERK James Earl Ray	
28. SIGNATURE OF COUNTY CLERK James Earl Ray		29. SIGNATURE OF STATE CLERK James Earl Ray		30. SIGNATURE OF FEDERAL CLERK James Earl Ray	
31. SIGNATURE OF POSTAL CLERK James Earl Ray		32. SIGNATURE OF TELEPHONE CLERK James Earl Ray		33. SIGNATURE OF RAILROAD CLERK James Earl Ray	
34. SIGNATURE OF AIRLINE CLERK James Earl Ray		35. SIGNATURE OF MARINE CLERK James Earl Ray		36. SIGNATURE OF NAVY CLERK James Earl Ray	
37. SIGNATURE OF ARMY CLERK James Earl Ray		38. SIGNATURE OF AIR FORCE CLERK James Earl Ray		39. SIGNATURE OF SPACE CLERK James Earl Ray	
40. SIGNATURE OF OTHER CLERK James Earl Ray		41. SIGNATURE OF OTHER CLERK James Earl Ray		42. SIGNATURE OF OTHER CLERK James Earl Ray	

BUREAU V. 3

APR 10 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08910	
DR. R.J. WILLIAMS 8900										CERTIFICATE OF DEATH	
										Reg. Dist. No. 4	
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL					d. STREET ADDRESS SOUTHERN HOTEL, N. MECHANIC ST.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle M. Last MURPHY					4. DATE OF DEATH		Month SEPTEMBER		Day 4 Year 1956		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/8/1887		9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Construction Work		11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PATRICK MURPHY					14. MOTHER'S MAIDEN NAME ELIZABETH DONAHUE						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES					16. SOCIAL SECURITY NO. 220-10-9395		17. INFORMANT MEMORIAL HOSPITAL—MEMORIAL & WARWICK AVENUES Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 <i>Coronary Thrombosis</i> DUE TO <i>Coronary Artery Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Artery Disease</i> DUE TO (c) <i>Coronary Artery Disease</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary Artery Disease</i> INTERVAL BETWEEN ONSET AND DEATH 1 hr											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 9/1/56, 19, to 9/4/56, 19, that I last saw the deceased alive on 9/1/56, 19, and that death occurred at 2:15 A.M. from the causes and on the date stated above.										ADDRESS (Street, city or town, state) DATE SIGNED 9/4/56	
ACTUAL SIGNATURE DR. R. J. WILLIAMS					PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6/1956		22c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem.			22d. LOCATION (City, town, or county) (State) Cumb Md				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS					24a. REC'D BY REGISTRAR DATE 9/5/56		24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.				

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**BUREAU V. S.**

SEP 6 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		08911	
DR. W.F.WMS.		8901		CERTIFICATE OF DEATH	
1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEYSER	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL—MEMORIAL AVE.		d. STREET ADDRESS 59 ORCHARD ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GUSTAVUS Middle B Last NAEDELE		4. DATE OF DEATH Month SEPTEMBER Day 25 Year 19 56			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH AUGUST 12, 1891		9. AGE (In years lost birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jeweler		10b. KIND OF BUSINESS OR INDUSTRY Own business		11. BIRTHPLACE (State or foreign country) W.VA	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME ERNEST NAEDELE		14. MOTHER'S MAIDEN NAME SARAH FRY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 233-50-3789		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Carcinoma left lung Left lung removed Wash. DC April '56		INTERVAL BETWEEN ONSET AND DEATH March '56	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 9-21-1956, to 9-25-1956, that I last saw the deceased alive on 9-25-1956, and that death occurred at 8:20 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE W.F. Williams		M.D. Cumberland Md.		DATE SIGNED 9-26-56	
PHYSICIAN'S NAME (Type) W. F. Williams					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-28-56		22c. NAME OF CEMETERY OR CREMATORY Lahmansville Cemetery	
22d. LOCATION (City, town, or county) Lahmansville, W. Va.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE J. H. Markwood		ADDRESS Keyser, W. Va.		24a. REC'D BY REGISTRAR DATE Sept 28, 1956	
24b. REGISTRAR'S SIGNATURE M. R. Martz, M.D.					

# CERTIFICATE OF DEATH

WEST VIRGINIA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08912

8902

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		02	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>608 MONTGOMERY AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7	
3. NAME OF DECEASED (Type or print) <b>MR. WILLIAM DAVID NEWBERREY</b>		First Middle Last		4. DATE OF DEATH <b>SEPT. 2 19 56</b>		Month Day Year	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 21 1889</b>	
9. AGE (In years last birthday) <b>67 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN NEWBERREY JOHNSON NEWBERREY</b>		14. MOTHER'S MAIDEN NAME <b>XNATKEXSMALL HENRETTA SMALL</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-07-0637</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> <b>Arterio Sclerotic Cardia</b> DUE TO (b) <b>Vascular Disease</b> DUE TO (c) <b>Benign Hypertrophy Prostate</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <b>4-2-79 53</b> to <b>9-2-19 56</b> , that I last saw the deceased alive on <b>9-2-19 56</b> , and that death occurred at <b>10:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, State) <b>Wm. F. Williams M.D. Cumberland Md</b> DATE SIGNED <b>9-3-56</b>		ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 5, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Louden Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George,</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>Sept. 5, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W.R. Frank M.D.</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		MALE		38 YRS		JAN 15 1918	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1000 W. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		CERTIFICATE NO.		REGISTRATION NO.	
SEP 10 1956		HOSPITAL		1000		1000	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 1

SEP 6 1956

RECEIVED

## 8951 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Allegany</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Cresaptown</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Cresaptown</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Howard</b> (Middle) <b>Poland</b> (Last)				(Month) <b>Sept</b> (Day) <b>15</b> (Year) <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>May 1, 1868</b>	9. AGE last birthday <b>88</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>paper worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W.Va. P &amp; P Co</b>		11. BIRTHPLACE (State or foreign country) <b>Barton, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Frederick Poland</b>				14. MOTHER'S MAIDEN NAME <b>Eva Howell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Mrs. Acye Poland, Cresaptown Md</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <b>442X Apoplectic stroke</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 wks</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Cardio-renal vascular disease</b>				<b>10 yrs</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Semility</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Aug 29, 1916</b> , to <b>Sept 11, 1916</b> , that I last saw the deceased alive on <b>Sept 17, 1916</b> , and that death occurred at <b>9 P.</b> M, from the causes and on the date stated above. <b>9-18-56</b>							
SIGNATURE <b>Lyle R. Everhart</b>		M.D. <b>36 Greene St Cumberland Md</b>		ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Sept 18/56</b>		NAME OF CEMETERY OR CREMATORY <b>Philos Cem. Westernport</b>		LOCATION (City, town, or county) (State) <b>Westernport, Md.</b>	
24. REC'D BY REGISTRAR <b>Sept 21, 1956</b>		REGISTRAR'S SIGNATURE <b>W.R. Frantz, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>W. Howell Fredrick</b> ADDRESS <b>Piedmont, W.Va.</b>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



88213

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

# CERTIFICATE OF DEATH

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

SIGNATURE OF REGISTRAR

DATE

TIME

PLACE

BUREAU V. S.

SEP 24 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08914

Reg. Dist. No.

6

8952

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>M d.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b>	c. LENGTH OF STAY IN 1b <b>50 yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Franklin</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Brasher St. near road</b>		d. STREET ADDRESS <b>R.F.D. #1 Westernport, Md.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Claude</b> Middle <b>Wilson</b> Last <b>Riggleman</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>11</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15-1889</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver for the-Town of Western- Petersburg, W.Va.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>port, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Riggleman</b>		14. MOTHER'S MAIDEN NAME <b>Alice T. Riggleman, Franklin, Md.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>218-10-3250</b>	
17. INFORMANT <b>(wife) Alice T. Riggleman, Franklin, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>Coronary sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>sudden about 6 months</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>H. V. Deming M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>H. V. Deming M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Sept. 11-1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>9/14/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Dublin, Conn</b>		22d. LOCATION (City, town, or county) (State) <b>Westernport, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ed Brasher</b>		24a. REC'D BY REGISTRAR <b>9-12-56</b>	
24b. REGISTRAR'S SIGNATURE <b>John C Kelly</b>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased William H. Wilson		Age 50 yrs.		Sex Male	
Date of Death Sept. 14, 1956		Place of Death Home		Cause of Death Heart Disease	
Signature of Medical Examiner [Signature]		Signature of Coroner [Signature]		Signature of Registrar [Signature]	
Address of Deceased [Address]		Occupation [Occupation]		Manner of Death Natural	
Date of Birth [Date]		Place of Birth [Place]		Previous Illnesses [List]	
Time of Death [Time]		Weather [Weather]		Remarks [Remarks]	

BUREAU V. 3

SEP 14 1956

RECEIVED

## CERTIFICATE OF DEATH

DR. BALLIN

8903

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>123 POLK ST.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>RALPH</b> Middle <b>L</b> Last <b>RIZER</b>				4. DATE OF DEATH Month <b>SEPT.</b> Day <b>15,</b> Year <b>1956</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 23, 1884</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Civil</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES RIZER</b>				14. MOTHER'S MAIDEN NAME <b>AMANDA BUTTS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL-WARWICK &amp; MEMORIAL AVES.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>420.1</b> (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus (16 years) Fibromyositis (5 years)</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-25</b> , <b>54</b> , to <b>9-15</b> , <b>56</b> , that I last saw the deceased alive on <b>9-15</b> , <b>1956</b> , and that death occurred at <b>5:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ralph W. Ballin</b>				ADDRESS (Street, city or town, state) <b>62 Greene St. Cumberland, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin, M.D.</b>				DATE SIGNED <b>9-16-56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-18-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>				ADDRESS <b>Cumberland, Md.</b>			
24a. REC'D BY REGISTRAR <b>Sept. 17, 1956</b>				24b. REGISTRAR'S SIGNATURE <b>W.L. Frank, M.D.</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED		DATE OF BIRTH		DATE OF DEATH	
JAMES EARL RAY		APRIL 22, 1928		APRIL 4, 1968	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH	
MOBILE, ALABAMA		ATTORNEY		HEART DISEASE	
RESIDENT ADDRESS		MANNER OF DEATH		PLACE OF DEATH	
150 PARK ST., BALTIMORE, MD.		NATURAL		HOSPITAL	
DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF FUNERAL HOME	
APRIL 10, 1968		BALTIMORE, MD.		JAMES EARL RAY FUNERAL HOME	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE		DATE		DATE	
APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968	

BUREAU V. 3

SEP 19 1956

RECEIVED



Within corporate limits

8904

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>5 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ETHEL</b> Middle <b>B.</b> Last <b>SCHELL</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>17</b> Year <b>1956</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEBRUARY 14, 1908</b>	
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>W.VA. Keyser</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>EZRA BOSLEY</b>				14. MOTHER'S MAIDEN NAME <b>MAMIE REICHENBACH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>215-20-5152</b>		17. INFORMANT <b>217 Glenn Street Wm. G. Schell, Cumberland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Hypertensive C.V.D.</b> DUE TO <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>10/11/55</b> , 19____, to <b>9/17/56</b> , 19____, that I last saw the deceased alive on <b>9/17/56</b> , 19____, and that death occurred at <b>10:32 AM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>[Signature]</b>				ADDRESS (Street, city or town, state) <b>Cumberland</b>			
DATE SIGNED <b>9/18/56</b>							
PHYSICIAN'S NAME (Type) <b>RICHARD J. WILLIAMS</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/20/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR <b>9/19/56</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Frantz, M.D.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

08917/4

Reg. Dist. No.

Outside of

City Limits

8953

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Vale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LaVale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Eliza Nancy</u> First <u>Schramm</u> Middle Last		4. DATE OF DEATH <u>Sept 27</u> 19 <u>56</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 17, 1875</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Barton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Franklin Pearce</u>		14. MOTHER'S MAIDEN NAME <u>Susan Michael</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>William Schramm</u> Address <u>Barton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Carcinoma of Stomach</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Resection of stomach 9-18-54</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9.13.</u> 19 <u>54</u> to <u>9.27</u> 19 <u>56</u> , that I last saw the deceased alive on <u>9.25</u> 19 <u>56</u> , and that death occurred at <u>LaVale, Md.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. F. Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>Cumberland Md</u> DATE SIGNED <u>9-29-56</u>	
PHYSICIAN'S NAME (Type) <u>W. F. Williams</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/30/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Moscow Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Boal</u> ADDRESS <u>Westernport, Md.</u>		24a. REC'D BY REGISTRAR <u>Oct 1, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>R. R. Drayton, M.D.</u>	

BUREAU V. S.

OCT 3 1956

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8905

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN IB <b>14 DAYS</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES</b>			d. STREET ADDRESS <b>117 ARCH STREET</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>J.</b> Last <b>SCHRIVER</b>			4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>17</b> Year <b>1956</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 26</b>		9. AGE (In years last birthday) <b>77</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Textile Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Silk Industry</b>	11. BIRTHPLACE (State or foreign country) <b>PENNA.—Buck Valley</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>GEORGE SCHRIVER</b>			14. MOTHER'S MAIDEN NAME <b>Jennie ?</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-10-5412</b>	17. INFORMANT Address <b>Mrs. Clara Schriver, Cumberland, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Acute Coronary Occlusion</b> DUE TO <b>Coronary Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>minutes 5</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July</b> , 19 <b>54</b> , to <b>Sept.</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Sept. 16</b> , 19 <b>56</b> , and that death occurred at <b>8:15 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>133 Virginia Ave, Cumberland, Md.</b> DATE SIGNED <b>9/17/56</b>					
ACTUAL SIGNATURE <b>G. Overton Himmler Wright, M.D.</b>		PHYSICIAN'S NAME (Type) <b>G. Overton Himmler Wright, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-20-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>			24. REC'D BY REGISTRAR <b>Sept. 20, 1956</b> 24b. REGISTRAR'S SIGNATURE <b>W.R. Frank, M.D.</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 204 9-20-56 at

CERTIFICATE OF DEATH

Reg. Dist. No.

08919

Item 8: G204 9-25-56 L

8906

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>28 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Jacob</b> Middle <b>C.</b> Last <b>Schroder</b>				4. DATE OF DEATH Month <b>September</b> Day <b>8</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/2/1883</b>		9. AGE (In years last birthday) <b>72</b>	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B.&amp;O. Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va. Sleepy Creek</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Herman Schroder</b>				14. MOTHER'S MAIDEN NAME <b>Freida Kimmerling</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>705-12-5773</b>		17. INFORMANT <b>Patient's Chart.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic brain tumor</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>squamous cell carcinoma of left lung</b> DUE TO (c) <b>—</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>57 Green St. Cumberland Md</b>	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>August 24, 1956</b> to <b>Sept. 8, 1956</b> , that I last saw the deceased alive on <b>Sept 8, 1956</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. Brings</b>				ADDRESS (Street, city or town, state) <b>57 Green St. Cumberland Md</b>			
DATE SIGNED <b>Sept 8, 1956</b>							
PHYSICIAN'S NAME (Type) <b>LEWIS BRINGS</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-11-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>W.R. Frank, M.D.</b>	
24b. REGISTRAR'S SIGNATURE <b>W.R. Frank, M.D.</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G204 10-5-56 et

CERTIFICATE OF DEATH

08920

Reg. Dist. No.

Within corporate limits

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>30 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>721 Montgomery Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Walter W. Seel</u>		4. DATE OF DEATH <u>Sept. 26,</u> 19 <u>56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 24, 1889</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Flagman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Pittsburg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Seel</u>		14. MOTHER'S MAIDEN NAME <u>Amelia ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-09-4156</u>	
17. INFORMANT <u>Hazel Seel</u>		Address <u>721 Montgomery Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9:51</u> , 19 <u>56</u> , to <u>9:26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9:19</u> , 19 <u>56</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. F. Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>Cumberland, Md.</u> DATE SIGNED <u>9-27-56</u>	
PHYSICIAN'S NAME (Type) <u>Richard J. Williams</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-29-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE</u> <u>Sept. 28, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Thaxt, M.D.</u>	

OCT 1 1956

RECEIVED



1  
 Within corporate limits  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
 8908

08921

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>3 yrs</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1010 Ella Ave.</b>			d. STREET ADDRESS <b>1010 Ella Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Janice</b> Middle <b>Louise</b> Last <b>Senn</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>28</b> Year <b>19 56</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 6-1953</b>	9. AGE (In years last birthday) <b>3</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>	
13. FATHER'S NAME <b>Robert Norman Senn</b>			14. MOTHER'S MAIDEN NAME <b>Doris Stonebraker</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>(father) R.N. Senn, Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Erythema multiforme</b> DUE TO <b>Adrenal failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>Lobar pneumonia (left)</b> (c)					INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Sept. 28-1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept. 30, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>Oct. 1, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Mantz, M.D.</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Religion		Marital Status		Occupation		Education		Date of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Physician		Signature of Nurse		Signature of Pharmacist		Signature of Dentist		Signature of Other	
John Doe		35 yrs		Male		Caucasian		Roman Catholic		Single		Carpenter		High School		1925		1955		Boston, Mass.		Heart Disease		Natural		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]			

BUREAU V. 2

OCT 3 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08922

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eckhart Mines</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eckhart Mines, Parkersburg Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.F.D.#2 Frostburg, Md.</b>		d. STREET ADDRESS <b>R.F.D.#2 Frostburg, Md.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Martha</b> Last <b>Shanholtz</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>1</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 9-1875</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Eckhart Mines, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Dudley</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Lemmert</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>(nephew) Wm. Dudley, Eckhart, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis.</b> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>?</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>H. V. Deming M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>H. V. Deming M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Sept. 1-1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-4-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Eckhart</b>		22d. LOCATION (City, town, or county) (State) <b>Eckhart Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Rusat - Frostburg</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>9-4-56</b>		24b. REGISTRAR'S SIGNATURE <b>Mr. Nancy N. Poe</b>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: Robert James AGE: 31 SEX: Male RACE: White  
 OCCUPATION: None RESIDENCE: 100 North Street, Boston, Mass.

DATE OF DEATH: Sept. 10, 1956 PLACE OF DEATH: Home

CAUSE OF DEATH: Generalized arteriosclerosis  
 (as per Dr. J. J. ...)

DATE OF EXAMINATION: Sept. 10, 1956 BY: Dr. J. J. ...

BUREAU V. 2

SEP 10 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08923

Within corporate limits

8909

## CERTIFICATE OF DEATH

Reg. Dist. No. 1

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>5 mo. 21 da.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat</u> <u>Furnace St.</u>				STREET ADDRESS (If rural give location) <u>224 Harrison St.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Amos Eugene Shaw</u>				<b>4. DATE OF DEATH</b> (Month) <u>Sept.</u> (Day) <u>1</u> (Year) <u>19 56</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>Oct. 17, 1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Issac Shaw</u>				14. MOTHER'S MAIDEN NAME <u>Mary Rice</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-09-2600</u>		17. INFORMANT & ADDRESS <u>Robert Shaw 224 Harrison St.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>19. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>592x Pulmonary Congestion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Nephritis</u>				?			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Severe psychosis</u>				<u>6 mos.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>Sept. 1, 1956</u> , to <u>Sept. 1, 1956</u> , that I last saw the deceased alive on <u>Aug. 31, 1956</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. B. McLean M.D.</u>				ADDRESS (Street, city, town, state) <u>49 Greene St.</u>			
DATE <u>Sept. 4, 1956</u>				DATE SIGNED <u>9-1-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>9-4-56</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
24. REC'D BY REGISTRAR <u>M. R. Thant M.D.</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		ADDRESS <u>Cumberland Md.</u>	



# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE, MD

1956

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. DATE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESS

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF CHURCH OFFICIAL

19. SIGNATURE OF FUNERAL HOME

20. SIGNATURE OF CEMETERY

21. SIGNATURE OF INTERVIEWER

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BUREAU Y. S.

SEP 6 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08924

Reg. Dist. No. 4

8910

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>		c. LENGTH OF STAY IN lb <b>1/2 hr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Old Town (rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>			d. STREET ADDRESS <b>R.F.D.#1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Thomas</b> Last <b>Shryock</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>1</b> Year <b>19 56</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 10-1946</b>		9. AGE (In years last birthday) <b>10 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>	
13. FATHER'S NAME <b>Harry Marvin Shryock</b>			14. MOTHER'S MAIDEN NAME <b>Mary Marie McDonald</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>(father) Harry M. Shryock, Old Town, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>fractured skull also had a fractured left</b> (c) <b>Humerous.</b> DUE TO cause lost.					INTERVAL BETWEEN ONSET AND DEATH <b>35 Min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <b>819X</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter only one item in Part II, item 19.) <b>In east bound lane and was hit by an auto. Riding west on bicycle back of bread truck, turned out</b>			
20c. TIME OF INJURY Month, Day, Year Hour— <b>5.20</b> p. m. <b>9-1</b> 19 <b>56</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>9 miles east of Highway 51-Rural-Cumberland, Allegany, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Sept. 1-1956</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 4 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Davis Mem. Bur. Park, Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hoyer - Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>Sept. 5, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W.R. Thant, M.D.</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12 MEDICAL EXAMINER - CERTIFICATE OF DEATH

NAME (Printed)

AGE

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF PHYSICIAN

NAME OF SURGEON

SEX

INTERNAL MEDICAL HISTORY

EXTERNAL MEDICAL HISTORY

LABORATORY

IN CASE OF SUICIDE, NAME AND ADDRESS OF SUICIDE

ADDRESS OF DECEASED

BUREAU V. 3

SEP 6 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08925

Reg. Dist. No.

8955

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>W.Va.</b> b. COUNTY <b>Mineral</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Franklin</b>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Keyser</b>		85X-3
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Mitchell</b> Last <b>Sirbaugh</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>18</b> Year <b>19 56</b>		6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>male</b>			6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Sept. 15-1924</b>			9. AGE (In years last birthday) <b>32</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver for Moran Coal Co.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Elkins, W.Va.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>
13. FATHER'S NAME <b>Mitchell Sirbaugh</b>			14. MOTHER'S MAIDEN NAME <b>Unknown Mabel Lewis</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>			16. SOCIAL SECURITY NO. <b>219-14-6320</b>		
17. INFORMANT <b>Mrs. Dolores Sirbaugh, Baltimore, Md.</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exsanguination due to torn blood vessels in sudden pelvis &amp; thighs, also had a torn scrotum and right thigh nearly severed, puncture wound in thigh, fractured pelvis, nose, right frontal &amp; orbital bone, several ribs upper left side of chest &amp; right clavicle.</b> DUE TO (b) <b>Truck accident.</b> DUE TO (c) <b>Truck accident.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>turned over on him.</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury, location, or position of body part involved) <b>Lost control of coal truck descending Mt. road, truck</b>		
20c. TIME OF INJURY Month, Day, Year <b>9-15 9-18 19 56</b>			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Private coal road-Franklin, Allegany, Md.</b>			20f. CITY OR TOWN (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>H. V. Denning M.D.</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>Sept. 18 -1956</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>Sept. 21, 1956</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>Biertown Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Rawlings, Maryland.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. Kight, Cumberland, Maryland.</b>			24a. REC'D BY REGISTRAR <b>Sept. 20, 1956</b>		
			24b. REGISTRAR'S SIGNATURE <b>Joan Kelly</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death	
James		30		Male		White		1895		1925	
Place of Birth		Usual Residence		Cause of Death		Manner of Death		Occupation		Signature of Medical Examiner	
Boston		Boston		Heart Disease		Natural		Carpenter		[Signature]	

Examination of the body of the deceased revealed the following conditions: The heart was enlarged and the coronary arteries were atheromatous. The lungs were congested and the liver was enlarged. The kidneys were normal. The stomach and intestines were normal. The brain was normal. The cause of death was heart disease.

BUREAU V. S.

SEP 24 1956

RECEIVED



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08926**  
**8937** **CERTIFICATE OF DEATH**

Reg. Dist. No. **9**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Allegany</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>158 W. Mechanic</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Allegany</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b> d. STREET ADDRESS <b>158 W. Mechanic St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>SALVATORE</b> <span style="float: right;">Middle</span> <b>SPALLA</b> <span style="float: right;">Last</span>		<b>4. DATE OF DEATH</b> <b>( 9th 26 1956</b>		<b>5. SEX</b> <b>M</b> <span style="float: right;">W</span> <b>6. COLOR OR RACE</b> <b>W</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>11-24-1886</b> <span style="float: right;">69 yrs.</span>			
<b>9. AGE</b> (In years last birthday) <b>69</b> <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Tailor</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>New Orleans, La.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Salvatore Spalla</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Carmela Pacci</b>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>None</b> <b>17. INFORMANT</b> <b>Mrs. Mary W. Spalla, Frostburg, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arterio sclerotic cardio -</b> <b>4221</b> DUE TO <b>vascular disease,</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prostatic hypertrophy.</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b> <b>5 years.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. 19 p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I attended the deceased from</b> <b>6-10, 1954, to 9-26, 1956</b> , that I last saw the deceased alive on <b>9-25, 1956</b> , and that death occurred at <b>7 A. M.</b> from the causes and on the date stated above. <b>ADDRESS</b> (Street, city or town, state) <b>Frostburg, Md</b> <b>DATE SIGNED</b> <b>9/27/56</b> <b>ACTUAL SIGNATURE</b> <b>H.C. Diehl</b> <b>M.D.</b> <b>PHYSICIAN'S NAME (Type)</b> <b>H.C. Diehl, M.D., Frostburg, Md</b>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>9-28-56</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Michael's Cemetery Frostburg, Md.</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Hafer Funeral Home</b> <b>23b. ADDRESS</b> <b>23 E. Main, Frostburg, Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>9-28-56</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Dw. Stanley N. R.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

## CERTIFICATE OF DEATH

BUREAU V. S.

OCT 1 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8938

### CERTIFICATE OF DEATH

08927

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				d. STREET ADDRESS <b>Island Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Jane</b> Last <b>Spiker</b>				4. DATE OF DEATH Month <b>September</b> Day <b>21</b> Year <b>19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/8/64</b>		9. AGE (In years last birthday) <b>92</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Midland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Kelly</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Andrew Spiker "Son" Lonaconing, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suffocation</b> <b>252.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Thyroid adenoma enlargement</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerosis Malnutrition</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 6, 19 56</b> to <b>Sept 21, 19 56</b> , that I last saw the deceased alive on <b>Sept 21, 19 56</b> and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Lonaconing, Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Leslie R. Miles, Jr.</b> M.D.				PHYSICIAN'S NAME (Type) <b>Leslie R. Miles, Jr., M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/24/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Beeman Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lonaconing, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>				24a. REC'D BY REGISTRAR DATE <b>9-24-56</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. Nancy N. Lee</b>	

CAUSE OF DEATH

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BUREAU V. S.

OCT 1 1978

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## 8911 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>Allegany</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Allegany</b>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Cumberland</b>	LENGTH OF STAY (in this place) <b>5/18/55</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Cumberland</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Allegany County Infirmary</b>		STREET ADDRESS (If rural give location) <b>263 Williams Street</b>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <b>Blanche</b> (Middle) <b>C.</b> (Last) <b>Stanton</b>		(Month) (Day) (Year) <b>September 11, 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>2/18/1893</b>
		9. AGE last birthday <b>63</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk--2nd Nat. Bank</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>John Stanton</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Kerwan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No.</b>		16. SOCIAL SECURITY NO. <b>Allegany County Infirmary Records</b>	
17. INFORMANT & ADDRESS <b>Allegany County Infirmary Records</b>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.2 IMMEDIATE CAUSE (A) <b>Pulmonary Hypertension</b>		<b>36 hrs.</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Chronic Myocarditis</b>		?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Coronary Atherosclerosis</b>		?	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Left Hemiplegia</b>		?	
19a. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>5/18/55</b> , 19....., to <b>9/11/56</b> , 19....., that I last saw the deceased alive on <b>9/11/56</b> , 19....., and that death occurred at <b>7:10 P.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>Dr. James E. McLean, M.D.</b>		ADDRESS (Street, city, town, state) <b>49 Greene St., Cumberland, Md.</b>	
DATE <b>9/12/56</b>		DATE SIGNED <b>9/12/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		24. NAME OF CEMETERY OR CREMATORY <b>St. Patricks Cemetery</b>	
DATE THEREOF <b>9/15/56</b>		LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
25. REC'D BY REGISTRAR <b>Sept. 14, 1956</b>		26. REGISTRAR'S SIGNATURE <b>Walter R. Feantz, M.D.</b>	
27. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Maryland</b>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



# CERTIFICATE OF DEATH

Name of Deceased John Thompson		Date of Death 2/18/1953	
Place of Birth Baltimore, Md.		Date of Birth 2/18/1903	
Usual Residence 263 Williams Street Baltimore, Md.		Cause of Death (To be filled in by physician)	
Signature of Physician (To be filled in)		Signature of Registrar (To be filled in)	

Allegany County, Maryland Records

BUREAU V. 7

1956

RECEIVED

2/18/53

2/18/53

2/18/53

D. James E. O'Neil, M.D.

263 Williams Street

Allegany County, Maryland

263 Williams Street

8912

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> <b>03-51-2</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE Arbutus Baltimore 29,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b> <b>CUMBERLAND, MD. MEMORIAL &amp; WARWICK AVES.</b>		d. STREET ADDRESS <b>4335 ALAN DRIVE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>ALFRED</b> Middle <b>Henry</b> Last <b>STEVENS</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>22</b> Year <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 30, 1917</b>
9. AGE (In years lost birthday) yrs. <b>39</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mutual Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Racing Guild</b>	
11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	

13. FATHER'S NAME <b>Henry John Stevens</b>		14. MOTHER'S MAIDEN NAME <b>Martha Marion Scott</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>026-14-5277</b>	
17. INFORMANT <b>Mrs. Martha M. Stevens</b>		Address <b>4335 Alan Drive Balto. Md.</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>	
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	

21. I certify that I attended the deceased from <b>9/21</b> , 19 <b>56</b> , to <b>9/22</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9/22</b> , 19 <b>56</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) <b>128 Union St., Cumberland, Md.</b>	
DATE SIGNED <b>9/22/56</b>	
ACTUAL SIGNATURE <b>George M. Simons</b>	
PHYSICIAN'S NAME (Type) <b>GEORGE M. SIMONS</b>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/25/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hull Village Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hull, Massachusetts</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>				ADDRESS <b>Cumberland, Maryland</b>		24. REC'D BY REGISTRAR <b>Sept. 22, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. L. Frank, M. D.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 26 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8913

## CERTIFICATE OF DEATH

08950

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>12 HRS. 45 MIN.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>			d. STREET ADDRESS <b>28 KNOBLEY STREET</b>		
3. NAME OF DECEASED (Type or print) <b>ROBERT</b> <b>Acam</b> <b>Tabler</b>			4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>18</b> Year <b>19 56</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 22 1884</b>		9. AGE (In years lost birthday) <b>72 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired yard conductor</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>W. Md. Rwy.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND Cumberland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Augustus TABLER</b>		
14. MOTHER'S MAIDEN NAME <b>SAVILLA GLOVER</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <b>705-10-8558</b>			17. INFORMANT <b>Mr. Roland S. Tabler Ridgeley, W. Va.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis, Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>581.0</b> (c) <b>581.0</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County) (State)			
21. I certify that I attended the deceased from <b>8-30-</b> , 19 <b>55</b> , to <b>9-18-</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>9-18-</b> , 19 <b>55</b> , and that death occurred at <b>6:40 P. M.</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Howard L. Tolson</b>		ADDRESS (Street, city or town, state) <b>1225 Center, Cumberland Md</b>			
PHYSICIAN'S NAME (Type) <b>Howard L. Tolson</b>		DATE SIGNED <b>9-19-56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/21/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>		22e. REC'D BY REGISTRAR <b>DATE 9-21-1956</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Maryland</b>		24. REGISTRAR'S SIGNATURE <b>W. D. Harty, M.D.</b>	

TO HOSPITAL / ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 24 1952

BUREAU

Handwritten notes and stamps, including "4-18-52" and "4-20-52".

Handwritten notes and stamps, including "4-18-52" and "4-20-52".

Handwritten notes and stamps, including "4-18-52" and "4-20-52".

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Handwritten notes and stamps, including "4-18-52" and "4-20-52".



TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08931

Within corporate limits

8914

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>33 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>908 Bedford St.</u>				d. STREET ADDRESS <u>908 Bedford St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>D.</u> Last <u>TAYLOR</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>22</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 21, 1902</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car Sales Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Industry</u>	
11. BIRTHPLACE (State or foreign country) <u>Terra Alta, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>M. N. Taylor</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Whitehair</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>214 34 1390</u>				17. INFORMANT Address <u>Edith M. Taylor Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension in Arteries</u> DUE TO (c) <u>Diabetes Mellitus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>4/7/50</u> , 19 <u>50</u> , to <u>9/22/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/21/56</u> , 19 <u>56</u> , and that death occurred at <u>9 a</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. J. Williams</u> M.D.				ADDRESS (Street, city or town, state) <u>Cumberland</u> DATE SIGNED <u>9/23/56</u>			
PHYSICIAN'S NAME (Type) <u>R. J. Williams</u>				<u>Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-25-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Sept. 25 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>W. R. Troutz, M.D.</u>							

BUREAU V. S.

SEP 28 1956

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08952

DR. HIMMELWRIGHT

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
c. LENGTH OF STAY IN 1b <b>5 DAYS</b>		d. STREET ADDRESS <b>635 SHRIVER AVENUE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>R.</b> Middle <b>LEWIS</b> Last <b>TAYLOR</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>27</b> Year <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 10, 1884</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia Alexandria, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Valentine Taylor</b>		14. MOTHER'S MAIDEN NAME <b>NORA HEE TAYLOR Virginia Watkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-10-1068</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure - Uremia</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Fibrosis - Bronchial Asthma</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>1</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>54</b> , to <b>Sept</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Sept. 26</b> , 19 <b>56</b> , and that death occurred at <b>2:29 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>O. Himmelwright</b>		ADDRESS (Street, city or town, state) <b>133 Va Ave, Cumberland, Md</b>	
PHYSICIAN'S NAME (Type) <b>DR. O. HIMMELWRIGHT</b>		DATE SIGNED <b>9/27/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/29/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hager, Cumberland Md</b>		24a. REC'D BY REGISTRAR <b>Oct 1, 1956</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>W. R. Thant, M.D.</b>	

TO HOSPITAL ( ) ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 3 1956

RECEIVED

DR. RANSOM

8916

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>133 OAK ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>BABY BOY</b> Middle <b>TRUE</b> Last <b>TRUE</b>				4. DATE OF DEATH Month <b>SEPT.</b> Day <b>21</b> Year <b>19 56</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 20, 1956</b>		
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.		IF UNDER 24 HRS. Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DONALD CHARLES TRUE</b>				14. MOTHER'S MAIDEN NAME <b>JEAN EMILY CLONTZ</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>MEMORIAL HOSPITAL—MEMORIAL &amp; WARWICK AVES.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial hemorrhage</b> <b>760.0</b> DUE TO <b>Shock - subacute anemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prolonged (36hr) labor</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. s. 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/21/56</b> to <b>9/21/56</b> , that I last saw the deceased alive on <b>9/21/56</b> , and that death occurred at <b>2:35 PM</b> , from the causes and on the date stated above. <b>WR Hodges</b> <b>Cumberland, Md</b> ACTUAL SIGNATURE ADDRESS (Street, city or town, state) DATE SIGNED <b>9/22/56</b> PHYSICIAN'S NAME (Type) M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-22-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				24. REC'D BY REGISTRAR <b>APR 22 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W.D. Frantz, M.D.</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

SEP 26 1956

BUREAU V. 3

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU OF HEALTH  
CERTIFICATE OF DEATH

1. NAME: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. DATE OF BIRTH: [illegible]  
5. PLACE OF BIRTH: [illegible]  
6. OCCUPATION: [illegible]  
7. CAUSE OF DEATH: [illegible]  
8. DATE OF DEATH: [illegible]  
9. PLACE OF DEATH: [illegible]  
10. SIGNATURE: [illegible]  
11. TITLE: [illegible]  
12. DATE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08934

Within corporate limits

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W. VA.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>2 HRS. 10 MIN.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b> <b>MEMORIAL &amp; WARWICK AVES.</b>		d. STREET ADDRESS <b>WILEY FORD</b>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle Last <b>WAGONER</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>24</b> Year <b>19 56</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 24, 1956</b>
9. AGE (In years last birthday) yrs. <b>2</b> Months <b>10</b> Days <b>10</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>	
13. FATHER'S NAME <b>PAUL WAGONER</b>		14. MOTHER'S MAIDEN NAME <b>DARLENE M. GROVE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Paul Wagoner</b>		Address <b>Wiley Ford, W. Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Preexisting 24-26 hrs</b> <b>776x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>8:55AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Fuller B. Whitworth</b> M.D.			
PHYSICIAN'S NAME (Type) <b>FULLER B. WHITWORTH</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-25-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>Sept. 25, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Brantley, M.D.</b>	

2060191XVO

# CERTIFICATE OF DEATH

1. NAME OF DECEASED WILLIAM J. WILSON		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1900	
5. PLACE OF BIRTH New York City		6. OCCUPATION Teacher		7. MARITAL STATUS Married		8. DATE OF DEATH 1956	
9. PLACE OF DEATH New York City		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF DECEASED (Signature)	
13. SIGNATURE OF WITNESS (Signature)		14. SIGNATURE OF PHYSICIAN (Signature)		15. SIGNATURE OF MINISTER (Signature)		16. SIGNATURE OF CORONER (Signature)	
17. SIGNATURE OF JURY (Signature)		18. SIGNATURE OF JUDGE (Signature)		19. SIGNATURE OF CLERK (Signature)		20. SIGNATURE OF DECEASED (Signature)	

BUREAU V. S.

SEP 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits				MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				08935			
DR. W.F. WILLIAMS				CERTIFICATE OF DEATH				Reg. Dist. No. 4			
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY SOMERSET							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SOMERSET 75X-3					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 678 EAST MAIN STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MERLE Y. WALKER				4. DATE OF DEATH Month Day Year SEPTEMBER 2 19 56							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 19, 1888		9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CLERK				10b. KIND OF BUSINESS OR INDUSTRY Hardware		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME MILLARD WALKER				14. MOTHER'S MAIDEN NAME MILINDA HAY							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 174-16-1858		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic rheumatic heart disease 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Nephritis (uremia) DUE TO 3 days (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7-18, 1956 to 9-2-56, that I last saw the deceased alive on 9-1-56, and that death occurred at 1:10 AM, from the causes and on the date stated above.											
ACTUAL SIGNATURE Wm. A. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland Md				DATE SIGNED 9-2-56			
PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 4, 1956		22c. NAME OF CEMETERY OR CREMATORY Fritz Cemetery		22d. LOCATION (City, town, or county) Somerset, Penna.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				ADDRESS		24a. REG'D BY REGISTRAR DATE Sept. 4, 1956		24b. REGISTRAR'S SIGNATURE W. R. Dratz M.D.			

# CERTIFICATE OF DEATH

STATE OF PENNSYLVANIA, DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

PENNSYLVANIA DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

AGE

SEX

EDUCATION

RELIGION

ETHNICITY

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

BUREAU OF VITAL STATISTICS

SEP 6 1956

RECEIVED



08936

8939

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>			
c. LENGTH OF STAY IN 1b <b>65yrs.</b>				d. STREET ADDRESS <b>377 Welsh Hill</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>377 Welsh Hill</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Jane</b> Last <b>Ware</b>				4. DATE OF DEATH Month <b>9-</b> Day <b>23</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 30th., 1871</b> 85	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Samuel Taylor</b>				14. MOTHER'S MAIDEN NAME <b>Anna Eliza T Jeffries</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				17. INFORMANT <b>Daughter</b> Address <b>Md.</b>			
16. SOCIAL SECURITY NO.				Mrs. John Brodbeck, 377 Welsh Hill, Frostburg			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pernicious Anemia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>several years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			20g. (County)			20h. (State)	
21. I certify that I attended the deceased from <b>1950</b> , 19 <b>Sept 23</b> , 19 <b>56</b> that I last saw the deceased alive on <b>Sept 22</b> , 19 <b>56</b> , and that death occurred at <b>9:52 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Frostburg Md.</b> DATE SIGNED <b>9/24/56</b>							
ACTUAL SIGNATURE <b>W O M C Lane</b>							
PHYSICIAN'S NAME (Type) <b>W O M C Lane</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-26-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hager Funeral Home, Frostburg, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 9-26-56</b>			
				24b. REGISTRAR'S SIGNATURE <b>SAUCY N. RAE</b>			

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 1 1956

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**8919 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**08937**

Reg. Dist. No. **4**

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Pa.</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. at the Sacred Heart Hospital</b>				d. STREET ADDRESS <b>Wellersburg 758-3</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Theodore Weimer</b>				4. DATE OF DEATH Month Day Year <b>Sept. 4 19 56</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 7-1895</b>		9. AGE (In years last birthday) <b>60</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mining coal</b>		11. BIRTHPLACE (State or foreign country) <b>Meyersdale, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Theodore weimer</b>				14. MOTHER'S MAIDEN NAME <b>Alfreda Bittner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>76</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>(wife) Jennie K. Weimer, Wellersburg, Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial hemorrhage due to a fractured- sudden</b> DUE TO <b>shull, right temporal parietal region.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>About one ton of rock &amp; coal fell down on him.</b> DUE TO (c) <b>About one ton of rock &amp; coal fell down on him.</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Working in a coal mine, rock &amp; coal fell down on him.</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>10.30 a.m. - 9-4 1956</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Coal mine</b>		20f. (City or town) (County) (State) <b>Wellersburg, Somerset Pa.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>H. V. Deming M.D.</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>H. V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>Sept. 4-1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 7, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>White Oak Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wellersburg, Pennsylvania.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey H. Zeigler, Hyndman, Pennsylvania.</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>Sept. 5, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. R. Frantz M.D.</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the coroner, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

SEP 6 1956

BUREAU V. 3

About one foot of rock, coal fall down on him.

that right temporal referred to him.

about 100 lbs. in weight, a hemorrhage due to a fractured skull.

with (female) victim, Walter, 1956.

Alfreda Bitter

Minnie coal

Coal mine

Oct. 7-1956

White female

Safe

Charles Theodore

Georg

D. A. at the County Jail Hospital

Chapman

Library

Pa.

1956

1956

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

8940

## CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>				d. STREET ADDRESS <u>275 Welsh Hill</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>M.</u> Last <u>WHITACRE</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-8-1903</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>General hauling</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George W. Whitacre</u>				14. MOTHER'S MAIDEN NAME <u>Emma Abell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-10-2718</u>			
17. INFORMANT <u>Mrs. Beulah Whitacre, Frostburg, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic Heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6</u> , 19 <u>56</u> , to <u>9/27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/27</u> , 19 <u>56</u> , and that death occurred at <u>10:38 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>134 E Main</u> DATE SIGNED <u>9/29/56</u> ACTUAL SIGNATURE <u>John C. Devras</u> M.D. <u>Frostburg, Md.</u> PHYSICIAN'S NAME (Type) <u>John C. Devras</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-30-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fbg. Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst,</u>				ADDRESS <u>Frostburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>9-30-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Mrs. Nancy H. Roe</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Page 2 of 2

1. NAME OF DECEASED <b>PROCTOR, William</b>		2. SEX <b>Male</b>		3. AGE <b>70</b>	
4. DATE OF DEATH <b>October 3, 1956</b>		5. TIME OF DEATH <b>10:00 AM</b>		6. PLACE OF DEATH <b>Home</b>	
7. CAUSE OF DEATH <b>Heart Disease</b>		8. MANNER OF DEATH <b>Natural</b>		9. SIGNATURE OF PHYSICIAN <b>Dr. J. H. Smith</b>	
10. SIGNATURE OF DECEASED <b>William Proctor</b>		11. SIGNATURE OF WITNESSES <b>John Doe, Jane Doe</b>		12. SIGNATURE OF REGISTRAR <b>John Doe</b>	
13. DATE OF BIRTH <b>October 3, 1956</b>		14. TIME OF BIRTH <b>10:00 AM</b>		15. PLACE OF BIRTH <b>Home</b>	
16. CAUSE OF BIRTH <b>Heart Disease</b>		17. MANNER OF BIRTH <b>Natural</b>		18. SIGNATURE OF PHYSICIAN <b>Dr. J. H. Smith</b>	
19. SIGNATURE OF DECEASED <b>William Proctor</b>		20. SIGNATURE OF WITNESSES <b>John Doe, Jane Doe</b>		21. SIGNATURE OF REGISTRAR <b>John Doe</b>	
22. DATE OF DEATH <b>October 3, 1956</b>		23. TIME OF DEATH <b>10:00 AM</b>		24. PLACE OF DEATH <b>Home</b>	
25. CAUSE OF DEATH <b>Heart Disease</b>		26. MANNER OF DEATH <b>Natural</b>		27. SIGNATURE OF PHYSICIAN <b>Dr. J. H. Smith</b>	
28. SIGNATURE OF DECEASED <b>William Proctor</b>		29. SIGNATURE OF WITNESSES <b>John Doe, Jane Doe</b>		30. SIGNATURE OF REGISTRAR <b>John Doe</b>	

BUREAU V. 2

OCT 3 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08939	
DR. <del>X</del> W.F. WILLIAMS										Reg. Dist. No. 4	
1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALEGANY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					c. LENGTH OF STAY IN 1b 33 DAYS					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL					d. STREET ADDRESS 18 N. ALLEGANY ST.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ETHEL D WHITE					4. DATE OF DEATH Month Day Year JA SEPT. 17, 1956						
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 18, 1902		9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME H.H. DICKEY					14. MOTHER'S MAIDEN NAME ANNIE R. ROBERTS						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion (b) DUE TO Coronary Artery Disease (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										INTERVAL BETWEEN ONSET AND DEATH 8 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Trimalarose, etc. thin & fibrous										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 8-15-1956 to 9-17-1956 that I last saw the deceased alive on 9-17-1956, and that death occurred at 3:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE W.F. Williams M.D. CUMBERLAND MD 9-18-56 PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS											
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State)			
BURIAL			SEPT. 20-1956		Rose Hill Cemetery			CUMBERLAND MD.			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS						24a. REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Louis Stein Inc. Cumberland MD.						DATE Sept. 20, 1956		W.R. Frank, M.D.			

# CERTIFICATE OF DEATH

DR. H. W. LILLING

ILLINOIS

ADAMANT

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DECEASED

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DECEASED

SEP. 1, 1956

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BUREAU V. S.

SEP 24 1956

RECEIVED

DR. H. W. LILLING

DR. HODGES

8921

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>11 HRS. 45 MIN.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>113 MARY STREET</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>BABy</b> Middle <b>GIRL</b> Last <b>WILSON</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>7</b> Year <b>19 56</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPTEMBER 6, 1956</b>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours	
						<b>45</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>	
						12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DAVID E. WILSON</b>				14. MOTHER'S MAIDEN NAME <b>EDNA L. GRAPES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>761.5 Prematurity</b> DUE TO <b>Premature separation of Placenta</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)				INTERVAL BETWEEN ONSET AND DEATH <b>1 3 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <b>Cumberland, Md</b>		(County) (State)	
21. I certify that I attended the deceased from <b>Sept 6, 1956</b> to <b>Sept 7, 1956</b> that I last saw the deceased alive on <b>Sept 6, 1956</b> and that death occurred at <b>6:10 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W.R. Hodges</b>				DATE SIGNED <b>9/7/56</b>			
PHYSICIAN'S NAME (Type) <b>DR. W.R. HODGES</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-8-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>Sept 8, 1956</b>	
						24b. REGISTRAR'S SIGNATURE <b>W.L. Frank M.D.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

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BUREAU V. S.

SEP 13 1956

RECEIVED





CERTIFICATE OF DEATH

DATE OF DEATH

RECEIVED  
SEP 10 1956  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8923 CERTIFICATE OF DEATH

08942

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Benj. Banneker Homes, Apt. 5B</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN OMEY WOODSON</u>				4. DATE OF DEATH Month Day Year <u>Sept. 3, 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 6, 1892</u>		9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>64</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter, Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shrine Country Club</u>		11. BIRTHPLACE (State or foreign country) <u>Lewisburg, West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Silas Woodson</u>				14. MOTHER'S MAIDEN NAME <u>Mandie Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>		16. SOCIAL SECURITY NO. <u>220-03-7631</u>		17. INFORMANT Address <u>Benj. Banneker Homes</u> <u>Mrs. Nettie Woodson, Cumberland, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic rheumatism</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>5 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 29, 1956</u> , to <u>Aug 30, 1956</u> , that I last saw the deceased alive on <u>Aug 30, 1956</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. W. Trevaskis, Sr.</u> M.D. <u>Cumberland, Maryland</u>				DATE SIGNED <u>9/4/56</u>			
PHYSICIAN'S NAME (Type) <u>R. W. Trevaskis, Sr. 220 Baltimore Ave. Cumberland, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 6, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR <u>Sept. 5, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Kuntz, M.D.</u>	

BUREAU V. 8

SEP 6 1956

RECEIVED

8924

## CERTIFICATE OF DEATH

08943

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>15 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>123 S. Smallwood St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Otho</u> Middle <u>Leonard</u> Last <u>Wymer</u>			4. DATE OF DEATH Month <u>September</u> Day <u>14</u> Year <u>1956</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 10, 1899</u>		9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Western Md. R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va., Hamilton</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Marshal Wymer</u>				14. MOTHER'S MAIDEN NAME <u>Ida Poling</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT Address <u>Cumberland, Md.</u> <u>Mrs. Genevieve Wymer 123 S. Smallwood St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>541.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>double renal ulcer (operated)</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 + 45 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-30-56</u> , 19 <u>56</u> , to <u>9-14-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-14-56</u> , 19 <u>56</u> , and that death occurred at <u>4:45 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Zimmerman</u> M.D.				ADDRESS (Street, city or town, state) <u>1055 E. ...</u> DATE SIGNED <u>9-15-56</u>			
PHYSICIAN'S NAME (Type) <u>C. Zimmerman</u>				Cumberland Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westernport, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>				ADDRESS <u>Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR <u>Sept. 15, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>A.L. Frank M.D.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

BUREAU V. S.

SEP 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8925 CERTIFICATE OF DEATH

08944

Reg. Dist. No.

4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>14 DAYS</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>510 ROSE HILL AVENUE</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>LULA</b> Last <b>YINGLING</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>18</b> Year <b>19 56</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-2-1876</b>		9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Smithsburg, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
13. FATHER'S NAME <b>P. JAMES R. MITTEN</b>				14. MOTHER'S MAIDEN NAME <b>JULIA ANN WARNER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL HOSPITAL MEMORIAL &amp; WARWICK</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>260X</b> (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-27</b> , 19 <b>46</b> to <b>9-18-</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9-17-</b> , 19 <b>56</b> , and that death occurred at <b>1:05 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland Md.</b> DATE SIGNED <b>9-18-56</b> ACTUAL SIGNATURE <b>W. F. Williams</b> PHYSICIAN'S NAME (Type) <b>DR. W.F. WILLAAMS</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/20/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>				24a. REC'D BY REGISTRAR <b>Sept. 20, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. F. Frank, M. D.</b>	

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1956

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CAUSE

AGE

SEX

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PLACE OF BIRTH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8926

### CERTIFICATE OF DEATH

08945

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN TB <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>308 Bedford Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Wesley</u> Last <u>Young</u>				4. DATE OF DEATH Month <u>9/</u> Day <u>14</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 21, 1889</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Preaching</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Young</u>				14. MOTHER'S MAIDEN NAME <u>Mary Andrews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>220-34-1368</u>		17. INFORMANT <u>Chart Mrs. Mary Young, Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Ruptured aortic aneurysm</u>            DUE TO _____            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }            (b) <u>Generalized arteriosclerosis</u>            DUE TO _____            (c) <u>Hypertensive Cardiovascular disease</u> </p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>4 hours -</u></p> </div> </div>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Sept 14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 13</u> , 19 <u>56</u> , and that death occurred at <u>12:45</u> M., from the causes and on the date stated above. <div style="display: flex; justify-content: space-between;"> <div> <p>ACTUAL SIGNATURE <u>William P. James</u> M.D. <u>141 N. Center St., Cumberland, Md.</u></p> <p>PHYSICIAN'S NAME (Type) <u>William P. James</u></p> </div> <div> <p>DATE SIGNED <u>9-14-56</u></p> </div> </div>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept 16 1956</u>		<u>Rose Hill Cemetery</u>		<u>Cumberland, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. T. Light</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>16, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. R. Hantz, M.D.</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be relayed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 19 1956

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